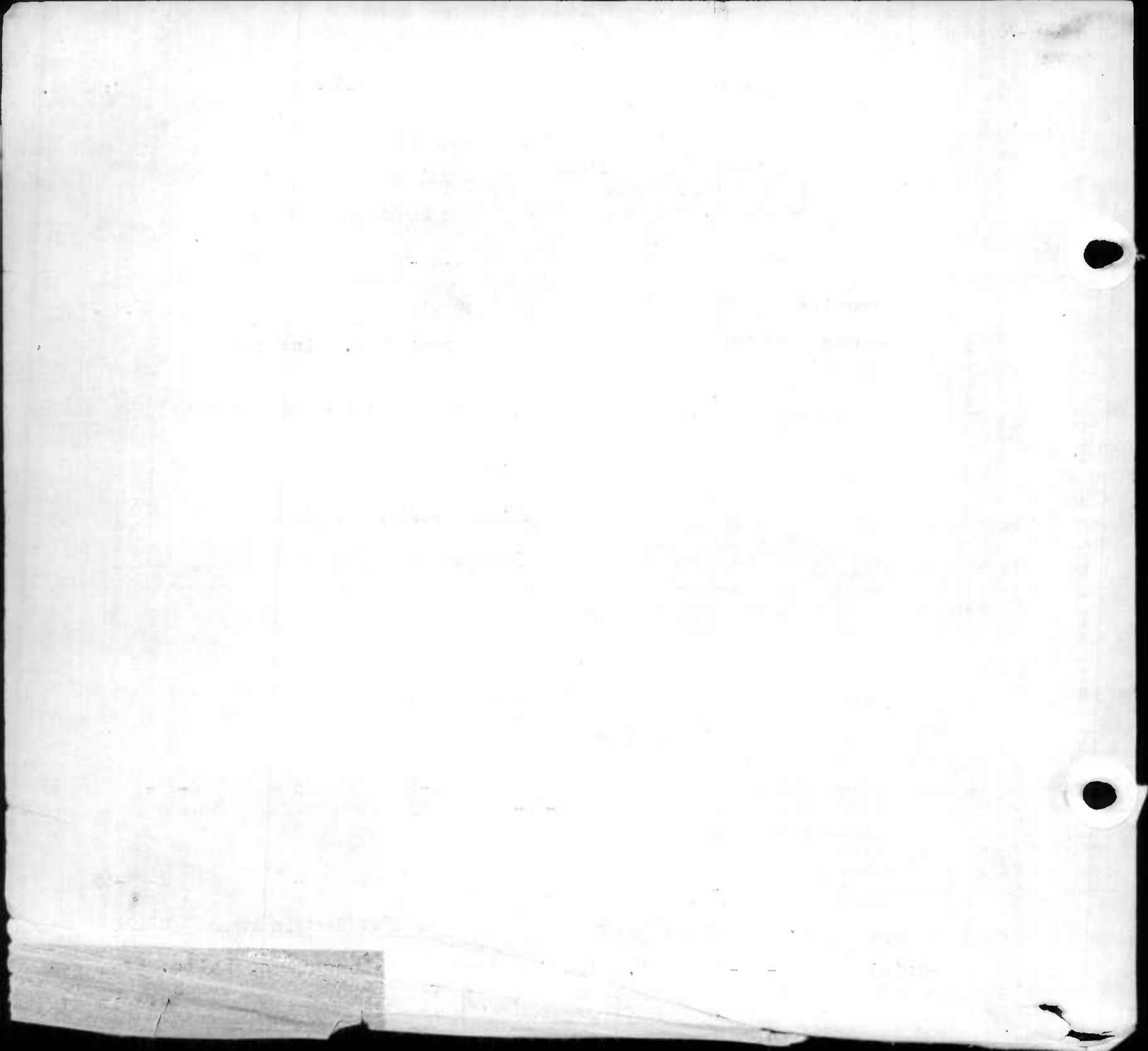


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 4502		65 4502	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		Gertrude Anderson		2. DATE AND HOUR OF DEATH 4-23-65 3:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 615 South Paca Street			
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 4-16-91	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Hawkins		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. 200X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Uremia DUE TO (B) Hydronephrosis, (R) Kidney DUE TO (C) Diabetes		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-19 19 65 to 4-23- 19 65, that (I) (we) last saw the deceased alive on 4-23- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Charles Carpenter				23B. DATE SIGNED 4-23-65	
23C. PHYSICIAN'S NAME (Type) Dr. Charles Carpenter				23D. ADDRESS 4940 Eastern Avenue #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-65		24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	
24D. LOCATION Longgreen, Balto. Co., Md.		24E. LOCATION (City, town, or county) (State) Biddle St			
25A. DATE REC'D BY HEALTH DEPT. APR 27 1965		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR 578 ADDRESS Biddle St	

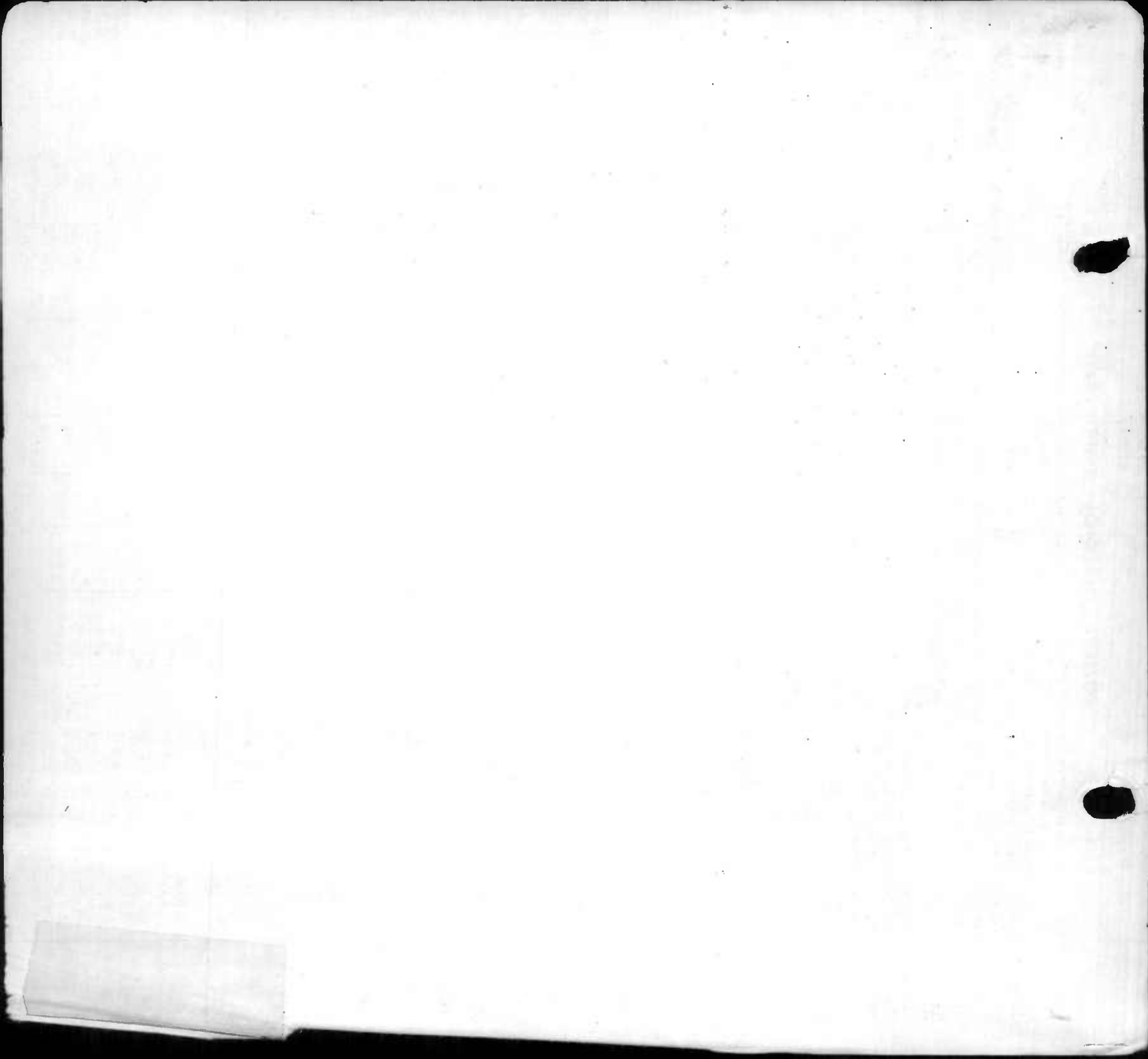




# FUNERAL DIRECTOR: IMPORTANT

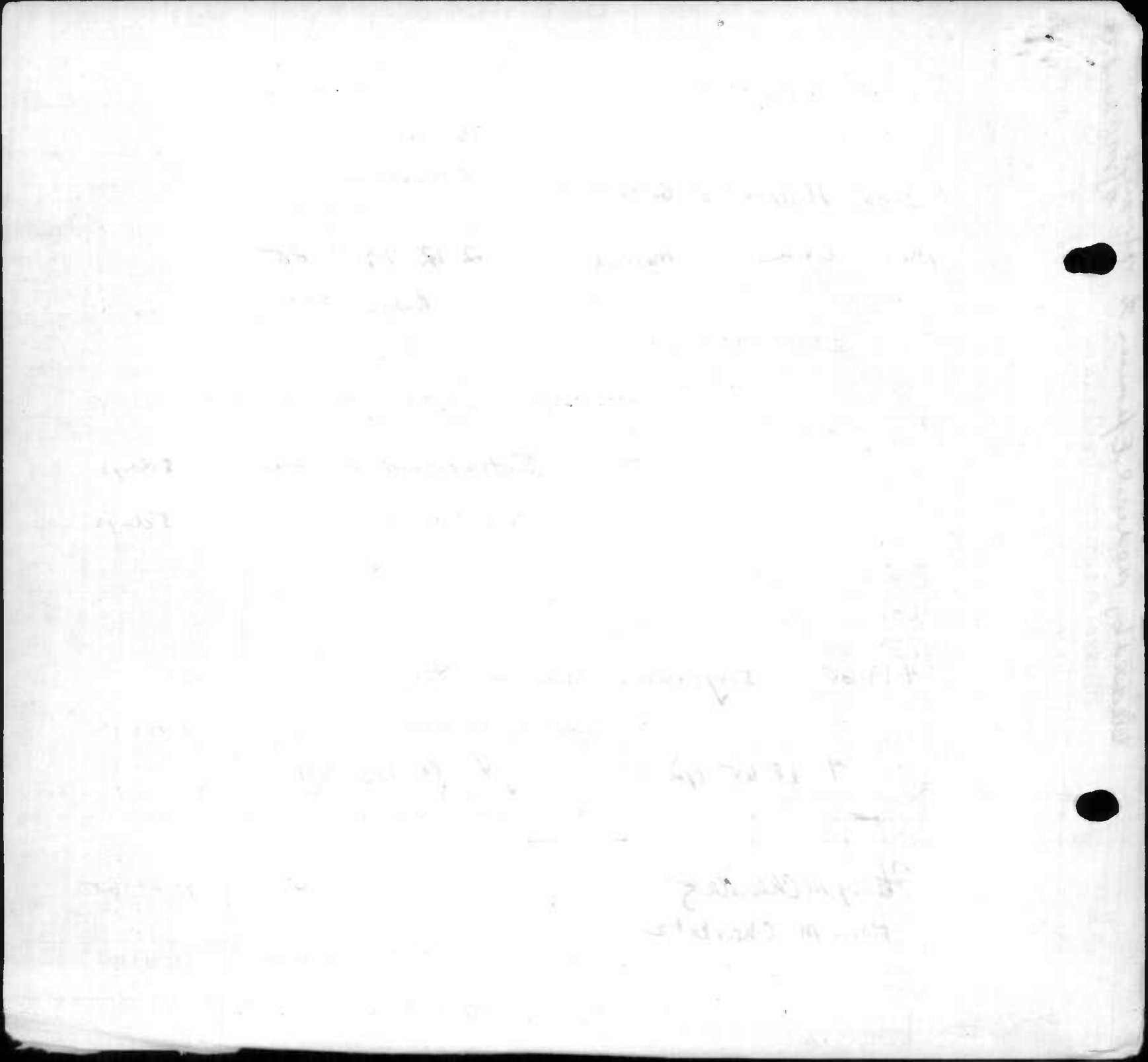
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4503	
BIRTH NO. 65-09737		M.E. CASE NO. 65 4503		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Boy "A" Witherspoon		2. DATE AND HOUR OF DEATH 4/24/65 6:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Guthrie Hospital of Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 707 Augusta Avenue			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4/24/65	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min. 20 minutes
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Steel Corp		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Allen Clayton Witherspoon		14. MOTHER'S MAIDEN NAME Patricia Lorraine Burton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) I immaturity		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 19 to 1965 19, that (I) (we) last saw the deceased alive on 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE APR 27 1965		24C. NAME of CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



Released by medical examiner to hospital  
K-656  
J.M. 6/2/65  
FURNAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

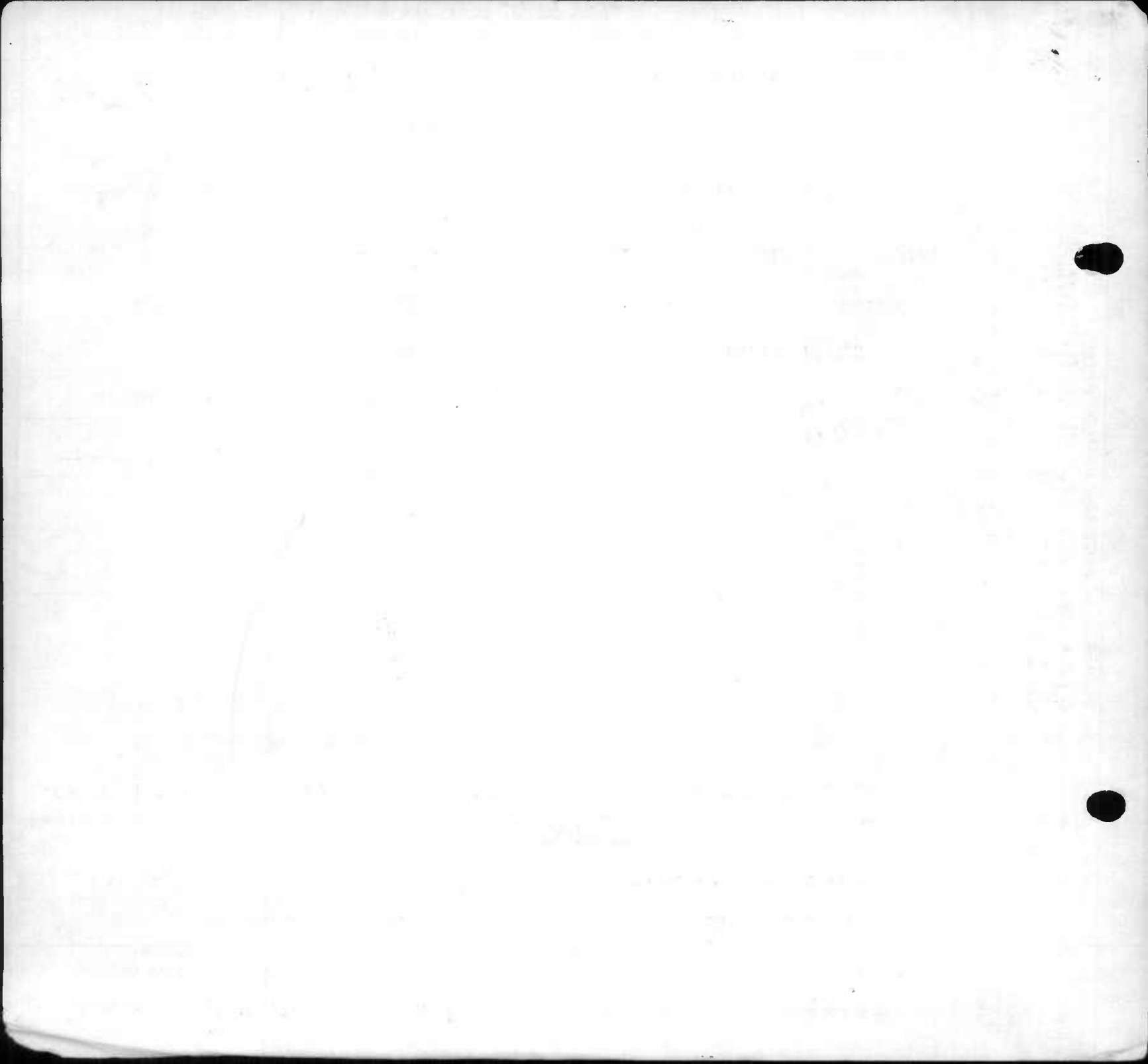
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4504	
BIRTH NO. 65 4504				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Kramer Louis</b>			4-24-65 4 p M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2720</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 Sinai Hospital of Baltimore</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3902 FORDLEIGH ROAD</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>XXXXXXXXXWIDOWED</b>	8. DATE OF BIRTH <b>2-12-79</b>	9. AGE (In years last birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>BERNARD SOLOMON KRAMER</b>		
14. MOTHER'S MAIDEN NAME <b>MARY ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>212-03-7250</b>			17. INFORMANT <b>MRS. HELEN GREENBERG 4010 FERNHILL AVE</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E904.71</b> <b>DUE TO</b> <b>Intracerebral hematoma</b> <b>5 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4-19-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracerebral hematoma</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Levinson Nursing Home - Greenspring &amp; Belvedere</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Pl. had fall</b>	
21D. TIME OF INJURY (APPROX.) <b>4 18 65 1pm</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pl. had fall</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>4-19-65</b> to <b>4-24-65</b> , that (I) <del>last</del> saw the deceased alive on <b>4-24-65</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>Harry M. Charkatz</b>				23B. DATE SIGNED <b>4-24-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harry M. Charkatz</b>				23D. ADDRESS <b>M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/26/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE</b>		24E. LOCATION (State) <b>MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 4505</span>					
BIRTH NO. <span style="font-size: 1.5em;">65 4505</span>		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ABRAHAM SHULMAN</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">APRIL 23, 1965</span> <span style="float: right; font-size: 1.5em;">4:50 P.M.</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">2520 LOYOLA SOUTHWAY</span>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2520 LOYOLA SOUTHWAY</span>					
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>			8. DATE OF BIRTH <span style="font-size: 1.2em;">MAR 16, 1897</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">FURRIER</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">RETAIL</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">RUSSIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">SAMUEL SHULMAN</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">RACHEL ?</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. ETTA SHULMAN 2520 LOYOLA SOUTHWAY</span>					
18. <span style="font-size: 1.5em;">420.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.5em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
					(A) <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span> DUE TO			<span style="font-size: 1.2em;">12 years</span>		
					(B) <span style="font-size: 1.2em;">none</span> DUE TO					
					(C) <span style="font-size: 1.2em;">none</span> DUE TO					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">April 30</span> 19 <span style="font-size: 1.2em;">53</span> to <span style="font-size: 1.2em;">April 23</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">April 23</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.										
23A. SIGNATURE <span style="font-size: 1.2em;">Manuel Levin</span>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.2em;">4/24/65</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MANUEL LEVIN</span>					23D. ADDRESS M.D. <span style="font-size: 1.2em;">4818 REISTERSTOWN ROAD</span>					
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">4/25/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">BNAI ISRAEL</span>			24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MARYLAND</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 28 - 1965</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farkas</span>			25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</span>				

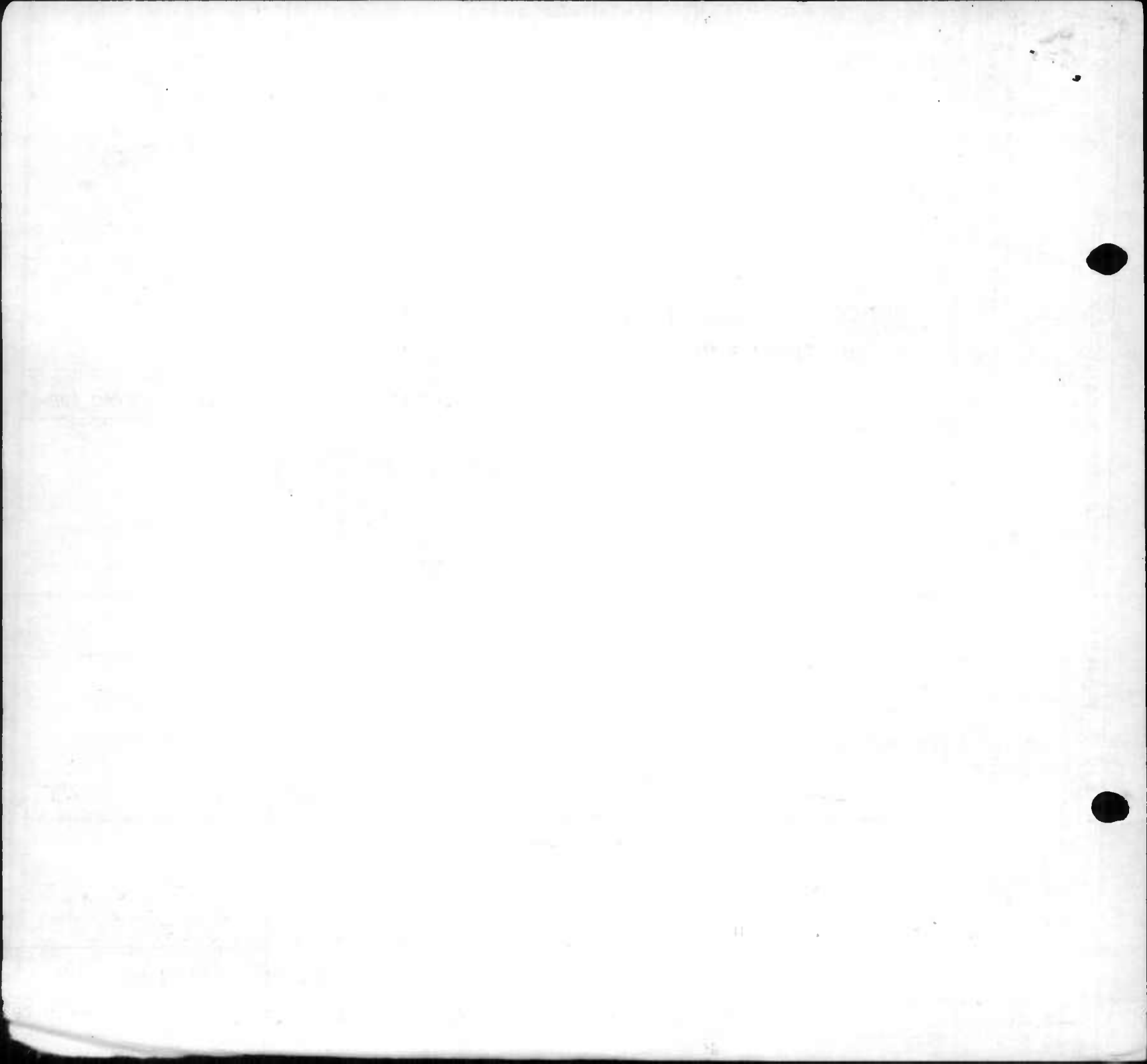


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4506</b>	
BIRTH NO. <b>65 4506</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED <i>Finkelstein Max</i>			
2. DATE AND HOUR OF DEATH <i>April 28, 1965 3:00 PM</i>		M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>		A. STATE <i>Maryland</i> B. COUNTY <i>1-83</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		D. STREET ADDRESS (If rural, give location) <i>638 S Kenwood Ave</i>			
8. DATE OF BIRTH <i>01-08-08</i> 9. AGE (In years last birthday) <i>5-7</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DRIVER</i>			
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>ABRAHAM FINKELSTEIN</i>		14. MOTHER'S MAIDEN NAME <i>SARAH ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MRS. CELIA FINKELSTEIN 638 S KENWOOD AVE</i>	
18. <i>331X I</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <i>Sepsis</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <i>Aspiration</i>			
		(C) <i>CVA</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>1/11</i> 19 <i>65</i> to <i>4/22</i> 19 <i>65</i> , that (1) <i>lost</i> saw the deceased alive on <i>4/22</i> 19 <i>65</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>did</i> (did not) view the body after death.					
23A. SIGNATURE <i>M. Lesch</i>				23B. DATE SIGNED <i>4/22/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. LESCH</i>				23D. ADDRESS <i>Johns Hopkins Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/25/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>BETH JACOB (VECAIR)</i>	
24D. LOCATION <i>ROSEDALE MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>			

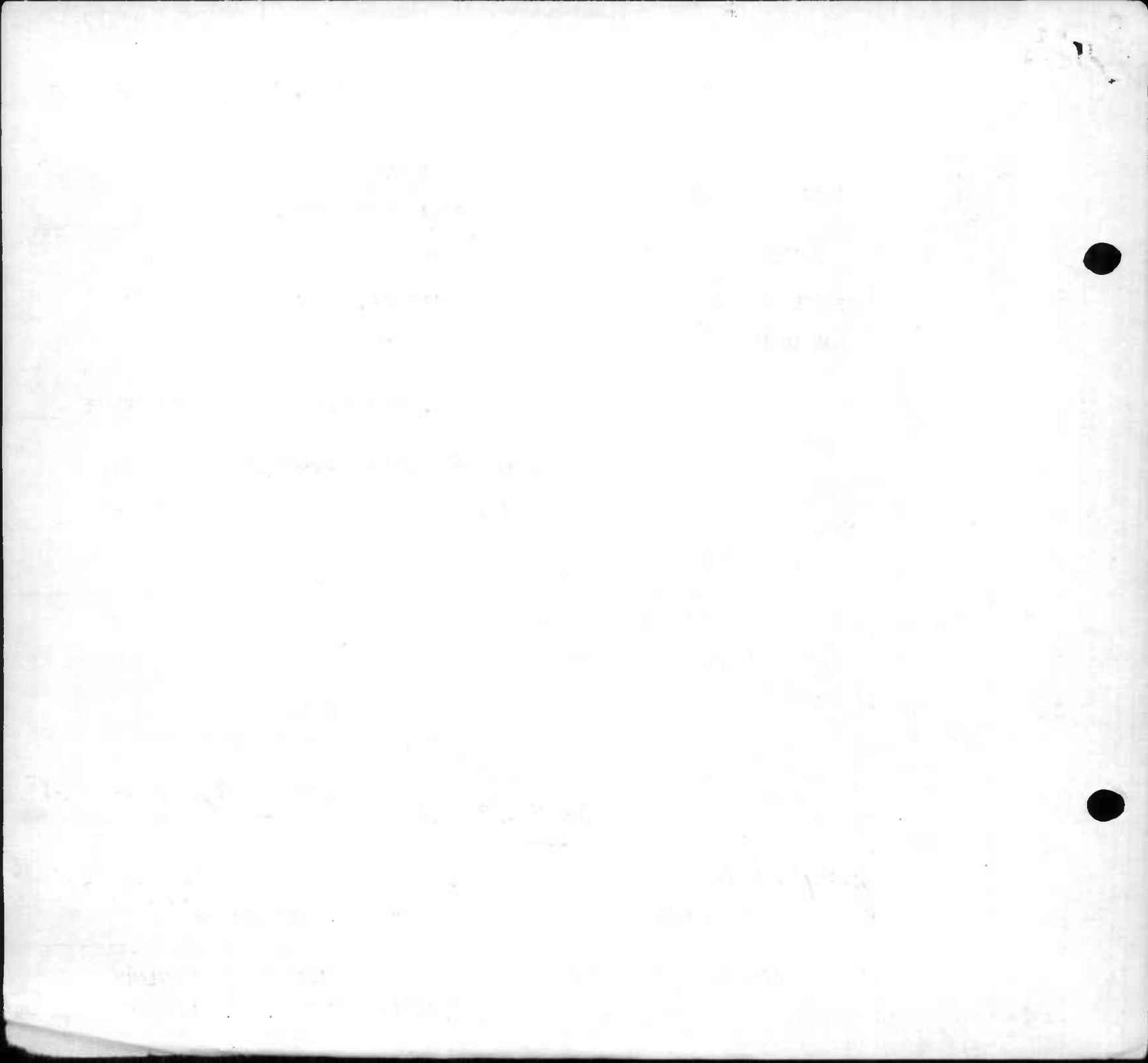




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4507					65 4507				
BIRTH NO.					REGISTERED NO.				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>HANNAH SPEAR</b>					2. DATE AND HOUR OF DEATH <b>APRIL 22, 1965</b> <b>1</b> <b>A.</b> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5054 CARMINE AVENUE</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5054 CARMINE AVENUE</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>60</b>	9. AGE (In years last birthday) <b>60</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MAX LURIE</b>					14. MOTHER'S MAIDEN NAME <b>IDA ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. LENA STEIN</b> ADDRESS <b>5737 JONQUIL AVENUE</b>			
18. <b>451X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <b>Ruptured Aortic aneurysm</b> DUE TO (B) <b>ASCD.</b> DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1967</b> to <b>April 22, 1965</b> , that (I) (we) lost saw the deceased alive on <b>April 20, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Joseph Shear MD</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>4/23/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH SHEAR</b>					23D. ADDRESS M.D. <b>6715 PARK HEIGHTS AVE</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/25/65</b>		24C. NAME of CEMETERY or CREMATORY <b>ANSHE EMUNAH</b>			24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>SOI LEVINSON &amp; BROS. INC. 6000 REISTERSTOWN RD</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4508</b>	
BIRTH NO. <b>65 4508</b>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>EMANUEL Caplan</b>		2. DATE AND HOUR OF DEATH <b>23 Apr. 65 12:10 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>THE Sinai Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-19</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. (MARRIED; NEVER MARRIED; WIDOWED; DIVORCED (specify)) <b>MARRIED</b>	
8. DATE OF BIRTH <b>10/20/00</b>		9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice Pres. Stores Corp. Goldenberg</b>	
11. BIRTHPLACE (State or foreign country) <b>Balt. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MEYER CAPLAN</b>	
14. MOTHER'S MAIDEN NAME <b>I DA ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-09-0861</b>	
17. INFORMANT <b>MRS. BESSIE CAPLAN</b>		ADDRESS <b>5810 PARK HEIGHTS AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary Edema</b>		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Acute Myocardial Infarct</b>					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Post TUR; 6 days</b>					
21A. DATE OF OPERATION <b>16 Apr.</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>23 P H</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6 Apr. 19 65</b> to <b>23 Apr. 19 65</b> , that (I) (we) last saw the deceased alive on <b>23 Apr. 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>23 Apr. 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ACEVEDO</b>		23D. ADDRESS <b>Sinai Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/25/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>	
24D. LOCATION (City, town, or county) <b>BALTIMORE</b>		(State) <b>MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>	
ADDRESS <b>6010 REISTERSTOWN RD</b>					

V.S. 153

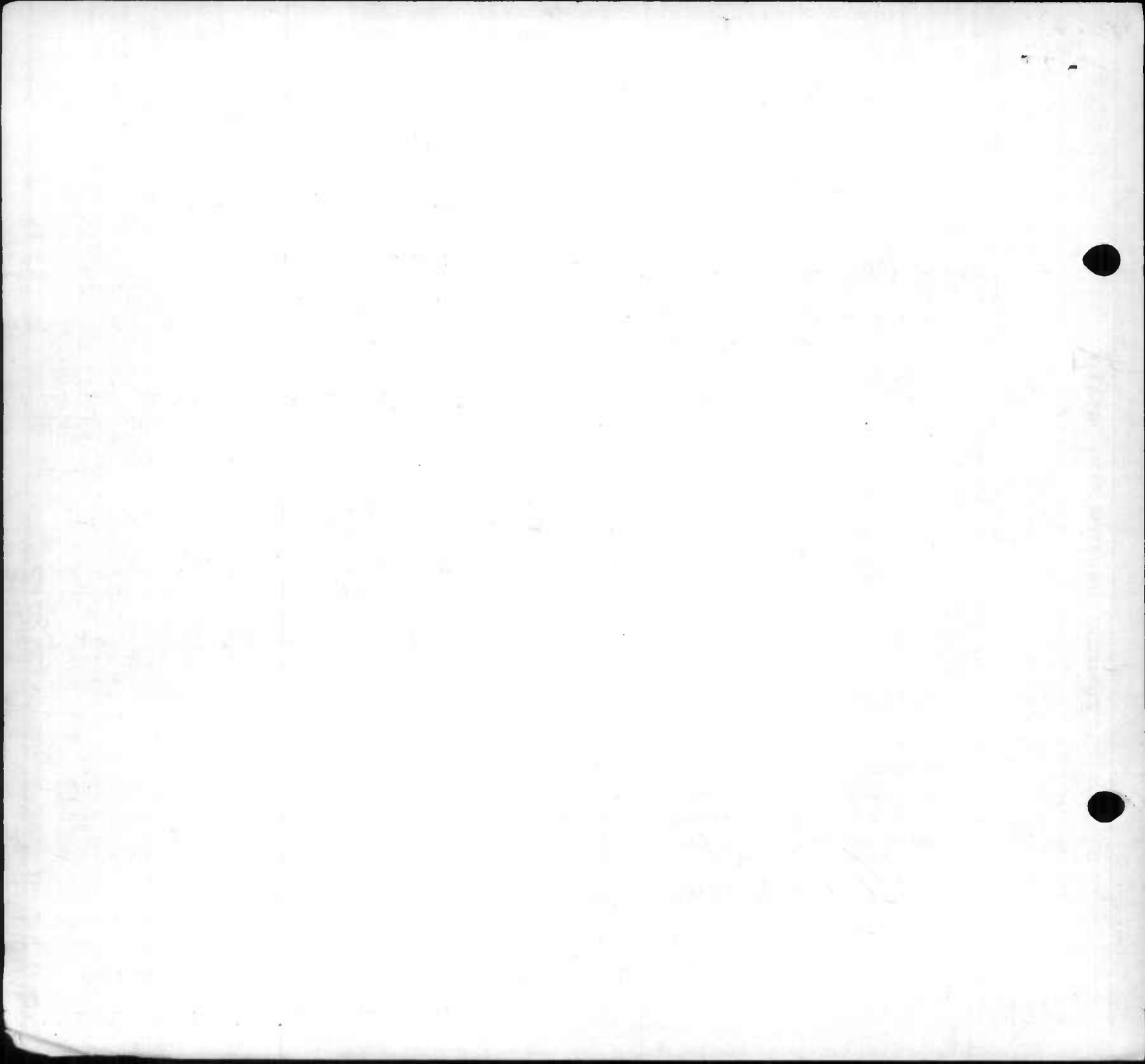
5-4-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4509	
CERTIFICATE OF DEATH					
BIRTH NO. 65 4509					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>SAM DEITCHMAN</u>		2. DATE AND HOUR OF DEATH <u>4/23/65</u> <u>1:50</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 SINAI Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>3312 CLARKS LANE APT A</u>			
5. SEX <u>MALE</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4/13/1922</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ISADORE DEITCHMAN</u>			14. MOTHER'S MAIDEN NAME <u>BESSIE MILLER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>MRS. MINNIE DEITCHMAN 3312 CLARKS LANE APT A</u>		
18. <u>7-33.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INSUFFICIENCY</u>		CAUSE OF DEATH (A) DUE TO <u>MYOCARDIAL INSUFFICIENCY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <u>CARDIAC ARRHYTHMIA</u>		<u>48 hrs</u>	
		(C) <u>MYOCARDIOPATHY ETIO UNK.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Probable Pulmonary Embolus</u>		<u>? 48 hrs - 96 hrs</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/21/65</u> 19 <u>65</u> to <u>4/23</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>4/23</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marvin L. Ginsburg</u> M.D.				23B. DATE SIGNED <u>4/23/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARVIN L. GINSBURG</u> M.D.				23D. ADDRESS <u>SINAI Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/25/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>BOBROISKER BENEFICIAL CIRCLE</u>	
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4510		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4510	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>Mr. Weisberg, Isadore</b>			2. DATE AND HOUR OF DEATH <b>4-24-65 6:15 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2720</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>9/Montebello S. Hospital</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b>		
			D. STREET ADDRESS (If rural, give location) <b>3903 Brookhill Road</b>		
5. SEX <b>MALE</b>	6. RACE <b>W HITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, <b>MARRIED</b>	8. DATE OF BIRTH <b>10-16-16</b>	9. AGE (In years last birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Expediter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>BENJAMIN WEISBERG</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) <b>YES WW 2 NAVY</b>			16. SOCIAL SECURITY NO. <b>212-03-2724</b>		
17. INFORMANT <b>MRS. ZELDA WEISBERG</b>			ADDRESS <b>3903 BROOKHILL RD</b>		
18. <b>193.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Oligodendroma of right cerebral hemisphere.</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9-2-1964</b> to <b>4-24-1965</b> , that (I) (we) last saw the deceased alive on <b>4-24-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Orlando C. Ramos</b> M.D.				23B. DATE SIGNED <b>4-24-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORLANDO C. RAMOS</b> M.D.				23D. ADDRESS <b>Montebello S. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/26/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH HAMEDROSH HAGODOL</b>	
24D. LOCATION <b>ROSEDALE</b>		24E. LOCATION (City, town, or county) (State) <b>MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Paul E. Fisher</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>	

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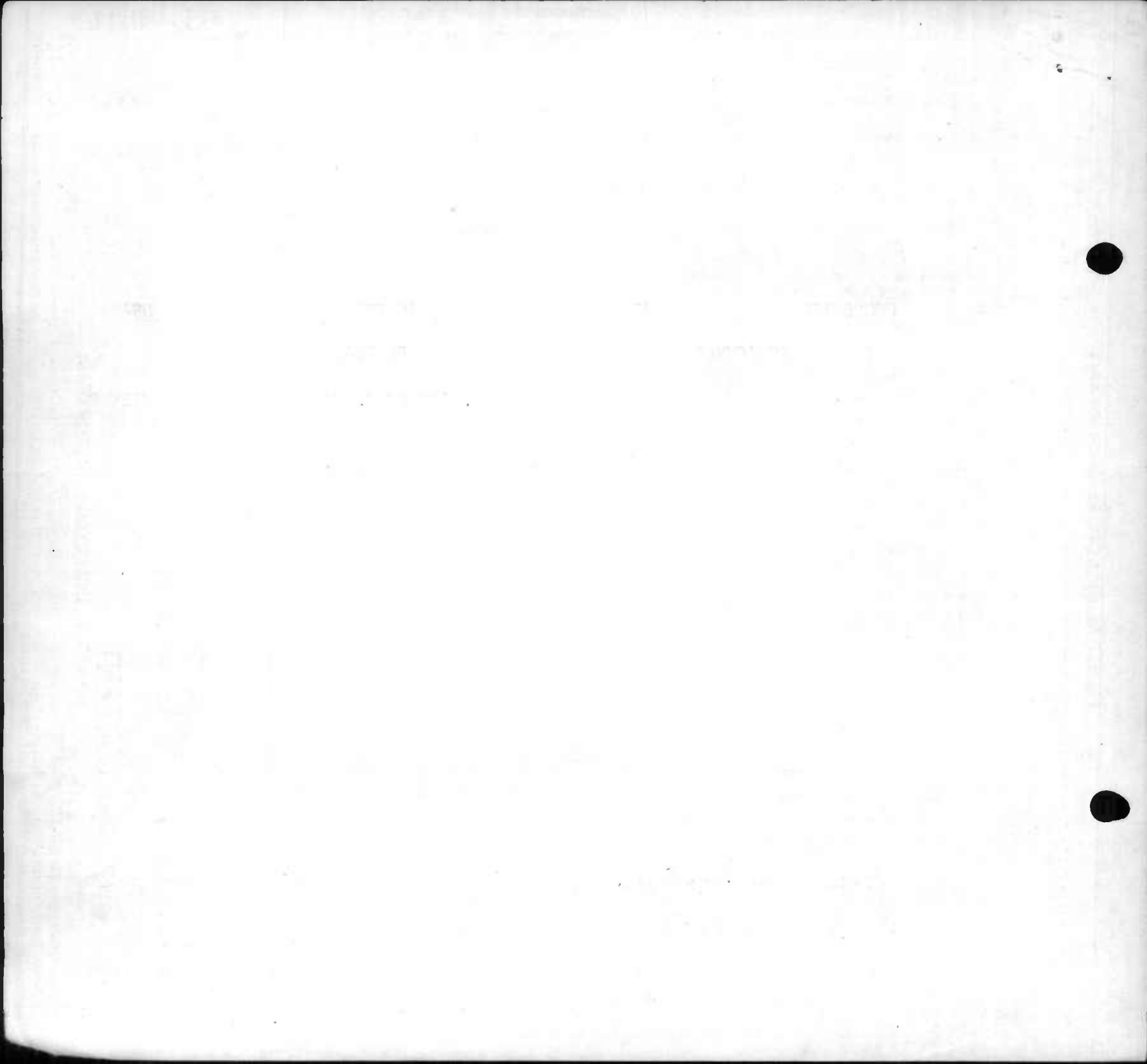
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# FUNERAL DIRECTOR: IMPORTANT

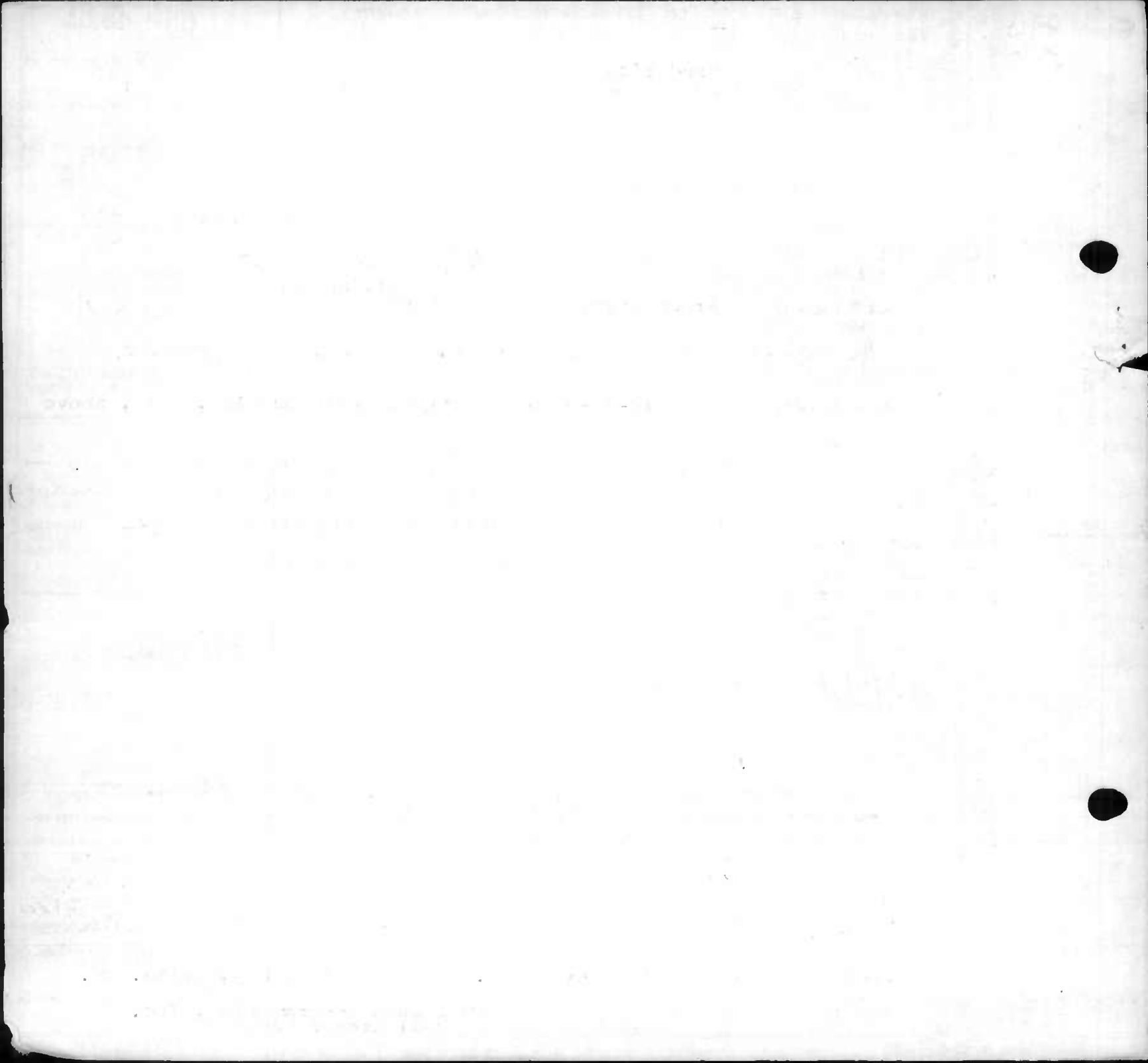
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4511				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4511	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Sadie Mandy</i>				2. DATE AND HOUR OF DEATH <i>4-24-65 9:46 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>md</i>		B. COUNTY <i>27-20</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>4012 Fords Lane</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Widowed</i>		8. DATE OF BIRTH <i>12-22-86</i>	9. AGE (In years last birthday) <i>78</i>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>AUSTRIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>? SCHACHNER</i>				14. MOTHER'S MAIDEN NAME <i>FREIDA ?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MR. ARTHUR J. MANDY 3600 GARDENVIEW RD</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>				CAUSE OF DEATH (A) <i>Myocardial Infarction</i> (B) <i>ASCVD</i> (C)		INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4-22</i> 19 <i>65</i> to <i>4-24</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-24</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard Gerald Shugerman, M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4/24/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Richard Gerald Shugerman, M.D.</i>				23D. ADDRESS <i>Sinai</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/26/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE HEBREW</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Faldut</i>		25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 4512		CERTIFICATE OF DEATH		65 4512	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Frederick CONRAD SCHULZE		4/26/65 9 15 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
35 CHURCH HOME HOSPITAL		MARYLAND 7-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE			
		D. STREET ADDRESS (If rural, give location)			
		803 N. CURLEY ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
M	W	MARRIED	6/9/1891	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RETIRED		Armco Steel	Baltimore MARYLAND		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ANDREAS SCHULZE			HENRIETTA GUNTHER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
UNKNOWN		212-10-6738	Gertrude Smith Schulze, wife, above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
154X I		POST-OPERATIVE MILES ABDOMINO - PERINEAL RESECTION (CA - Rectum)			
ANTECEDENT CAUSES		(B) GASTRIC HEMORRHAAGE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) RENAL FAILURE			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
1 3/19/65		CARCINOMA - RECTUM		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/11 19 65 to PRESENT 19 65 and that (I) (we) last saw the deceased alive on 4/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
C. BARTON GALLOWAY				4/26/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
C. BARTON GALLOWAY		104 W. MADISON ST. - BALTIMORE 31201			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/29/65		Glen Haven Mem. Park	
				24D. LOCATION (City, town, or county) (State)	
				Ritchie Hwy, Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 28 1965		R. E. F. J. M. A.		Sohimunek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

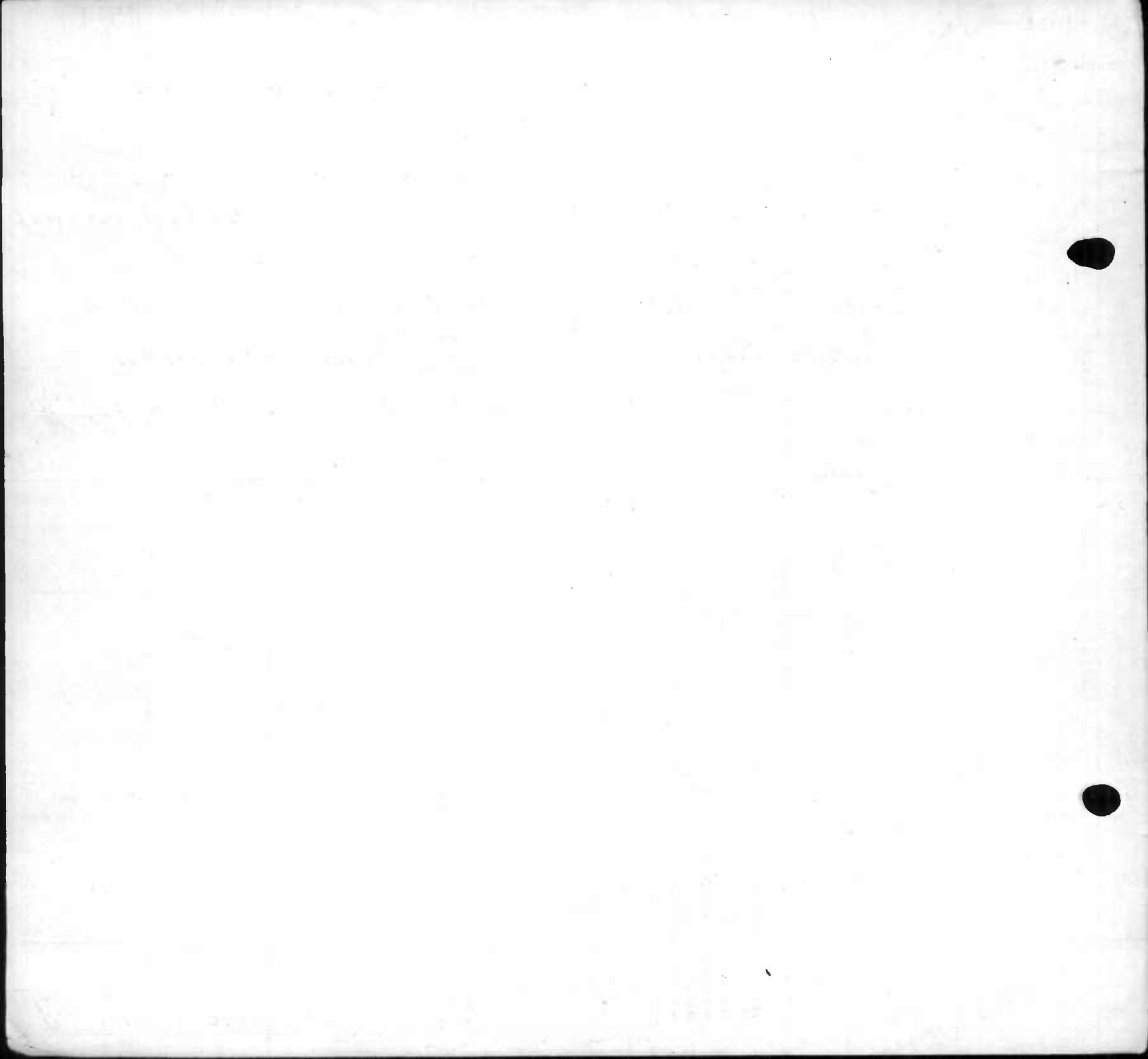
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 4513</u>				
BIRTH NO. <u>65 4513</u>					M.E. CASE NO. <u>65 4513</u>				
1. NAME OF DECEASED <u>Frances Marie Gillespie (Or Frances Marie)</u>					2. DATE AND HOUR OF DEATH <u>April 26 1965 9:30</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>35 Church home hospital</u>					A. STATE <u>Maryland</u>				
					B. COUNTY <u>7-02</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>825 N. Miltor Ave</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>			8. DATE OF BIRTH <u>Nov 30 1908</u>	9. AGE (In years last birthday) <u>56</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Shea</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Doulan</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>Wm. G. Gillespie, 2539 St. Paul St., 18</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>002.2.1 Pulmonary hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pulmonary Fibrosis</u>					<u>Years</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cor Pulmonale &amp; Congestive Heart failure</u>					<u>2 weeks</u>				
19A. DATE OF OPERATION <u>3 Apr 26 1965</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pulmonary insufficiency</u>			20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(1)</u> (this hospital) attended the deceased from <u>April 24</u> 19 <u>65</u> to <u>April 26</u> 19 <u>65</u> , that <u>(1)</u> (we) lost saw the deceased alive on <u>April 24</u> 19 <u>65</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>J. Howard Lutz</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>April 24 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Howard Lutz</u>					23D. ADDRESS <u>Church Home Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/29/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Schmucker Funeral Home, Inc. 2601 E. Madison St.</u>			









BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED  
(Type or Print)

ALICE

DORA JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

4-25-65

8:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

923 Collington Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
widowed

8. DATE OF BIRTH

July 23, 1884

9. AGE (In years  
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laundry Worker

10B. KIND OF BUSINESS OR INDUSTRY

Fulton Laundry

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Mitchell

14. MOTHER'S MAIDEN NAME

Dora DeGroff

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217-01-6896

17. INFORMANT

ADDRESS

Wm. G. Johnson, 2829 Brenden Ave., 13

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-26-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/29/65

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE RECD BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 28 1965

Robert E. Fisher

Schimunek Funeral Home, Inc.

2601 E. Madison St.

WATKINS POLICE

RECORDED

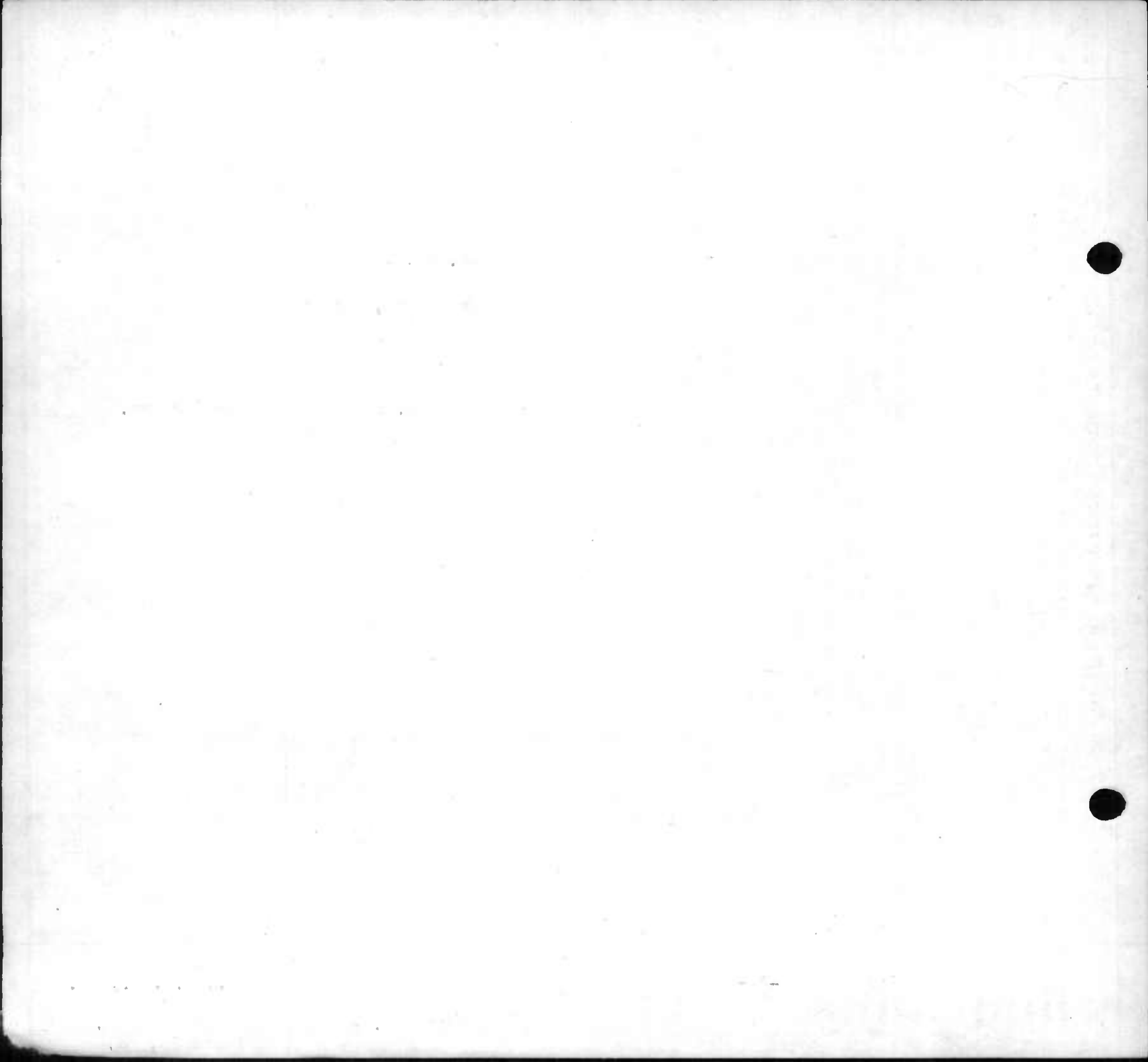
ST - 5-20-55 W. C. Johnson, 2825 R. Johnson Ave., 12  
Dora Dorelli  
William Mitchell  
Johnny Kottner  
Edison Lannery  
Baltimore, Md.  
July 12, 1954

Bureau 4/25/55  
London Park Cemetery, Baltimore, Md.  
Solomon's Funeral Home, Inc.  
2001 E. Redwood St.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4516					CERTIFICATE OF DEATH				
M.E. CASE NO. 65 4516					Registered No. 65 4516				
1. NAME OF DECEASED (Type or Print) <u>Florence Simmons</u>					2. DATE AND HOUR OF DEATH <u>4/24/65</u> <u>12:12 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>					A. STATE <u>Maryland</u> B. COUNTY <u>25-04</u>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>527 Pontiac Avenue</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 17, 1893</u>	9. AGE (In years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>					10B. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Frank Phillips</u>					14. MOTHER'S MAIDEN NAME <u>Rose Montgomery</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.				
17. INFORMANT <u>Arthur C. Simmons, 527 Pontiac Ave.</u>					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Generalized convulsions</u>					CAUSE OF DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <u>No</u>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>4/23/65</u> 19 <u>65</u> to <u>4/24</u> 19 <u>65</u> . that (I) ( <u>we</u> ) last saw the deceased alive on <u>4/24</u> 19 <u>65</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.									
23A. SIGNATURE <u>Perry S. Shelton</u>					23B. DATE SIGNED <u>4/24/65</u>				
23C. PHYSICIAN'S NAME (Type) <u>Perry S. Shelton</u>					23D. ADDRESS <u>Mercy Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>4027-1965</u>				
24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>					24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy., A.A.Co., Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				
25C. FUNERAL DIRECTOR <u>George J. Gonce</u>					ADDRESS <u>4001 Ritchie Hwy. Baltimore 25, Md.</u>				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

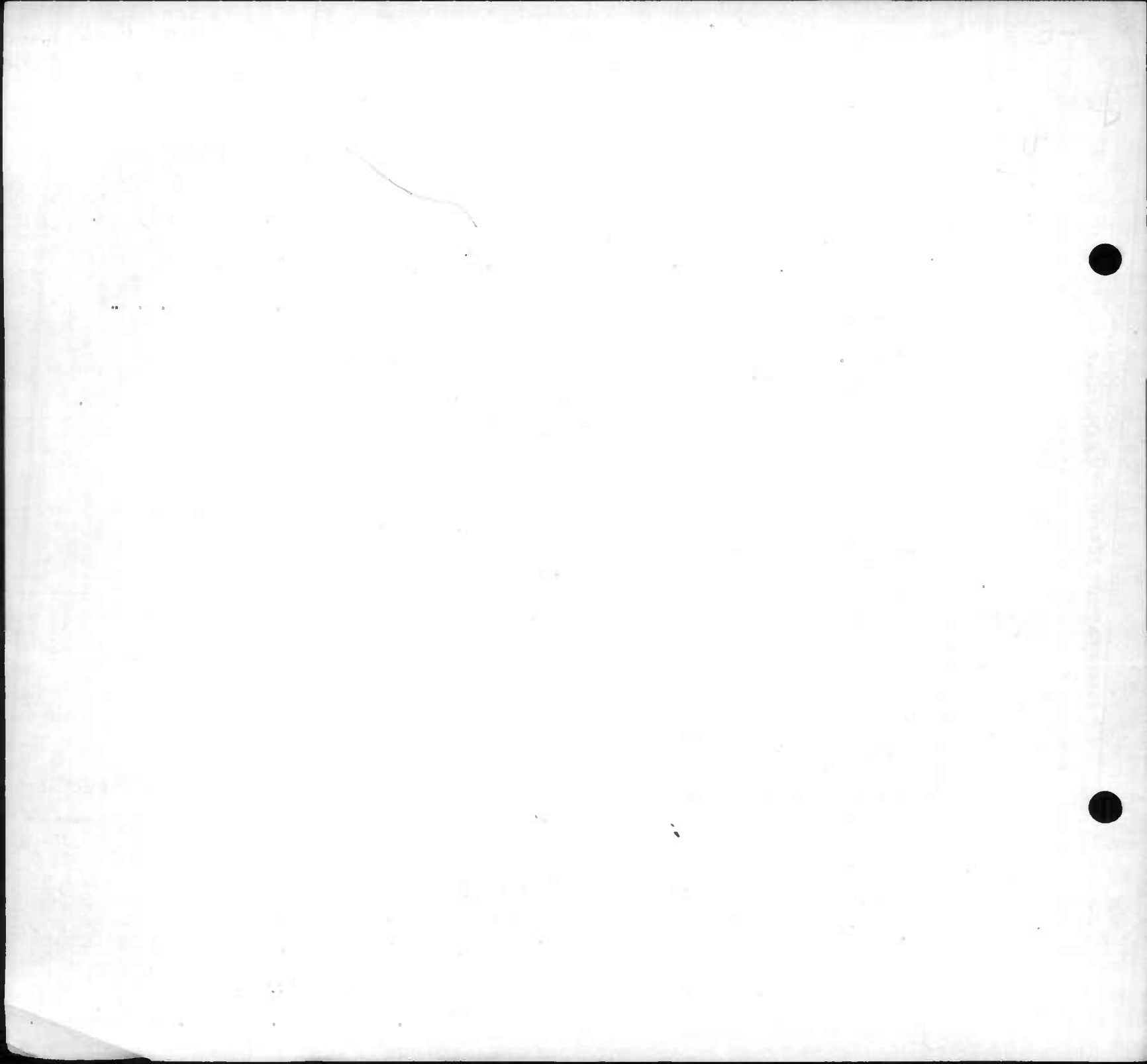
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 4517</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.5em;">65 4517</span></span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">URBAN, Mr. VERNON</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 25, 1965 12 midnite</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Church Home &amp; Hospital</span>			A. STATE <span style="font-size: 1.2em;">Maryland</span>		
			B. COUNTY <span style="font-size: 1.2em;">6-02</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 24</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">206 N. Melton Ave.</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <span style="font-size: 1.2em;">married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8-21-14</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">51</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">pipe fitter</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Charles Urban</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Genevieve Huron</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Davis Urban - 206 N. Melton Ave.</span>		
18. <span style="font-size: 1.2em;">737.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
			(A) <span style="font-size: 1.2em;">wound</span> DUE TO		<span style="font-size: 1.2em;">years</span>
		(B) <span style="font-size: 1.2em;">polycystic kidneys</span> DUE TO		<span style="font-size: 1.2em;">years</span>	
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-23-65</span> 19 to <span style="font-size: 1.2em;">4-25-65</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-25-65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Cesar R. Bariso</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">4-25-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CESAR R. BARISO</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">Church Home &amp; Hospital - Balto. 31, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/29/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore Cemetery</span>	
		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">John A. Moran, Inc. 3000 E. Baltimore St</span>	

1890  
The year of the  
great famine

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4518		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4518	
M.E. CASE NO.		CERTIFICATE OF DEATH		1965	
1. NAME OF DECEASED (Type or Print) <i>ELLA C. CROWE</i>		2. DATE AND HOUR OF DEATH <i>April 27-11 AM 1965</i> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Baltimore City, Maryland</i> B. COUNTY <i>Harford County, Md.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Harford County, Md.</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1124 Montpelier St. Baltimore, Md.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never</i>	8. DATE OF BIRTH <i>Dec. 26, 1903</i>	9. AGE (In years last birthday) <i>62 yrs.</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clerk</i>		11. BIRTHPLACE (State or foreign country) <i>Harford County, Md.</i>	
13. FATHER'S NAME <i>James J. Crowe</i>		14. MOTHER'S MAIDEN NAME <i>Mary Collison</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-7385</i>		17. INFORMANT ADDRESS <i>Miss Anne Crowe 1124 Montpelier St</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Acute Cardiac Disturbance</i> (B) <i>Diabetic Mellitus</i> (C) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1960</i> <i>1961</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>July 1960</i> 19 to <i>April 27</i> 19 <i>65</i> , that (I) <i>(do)</i> last saw the deceased alive on <i>April 27</i> 19 <i>65</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <i>(was)</i> <i>(did)</i> (did not) view the body after death. <i>Yes</i>					
23A. SIGNATURE <i>Dr. Charles P. Claudet</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>April 27, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR CHARLES P. CLAUDET</i>		23D. ADDRESS <i>3013 S. Paul St. Baltimore, Maryland</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/30/1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>John A. Moran Inc. 3000 E. Baltimore St.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

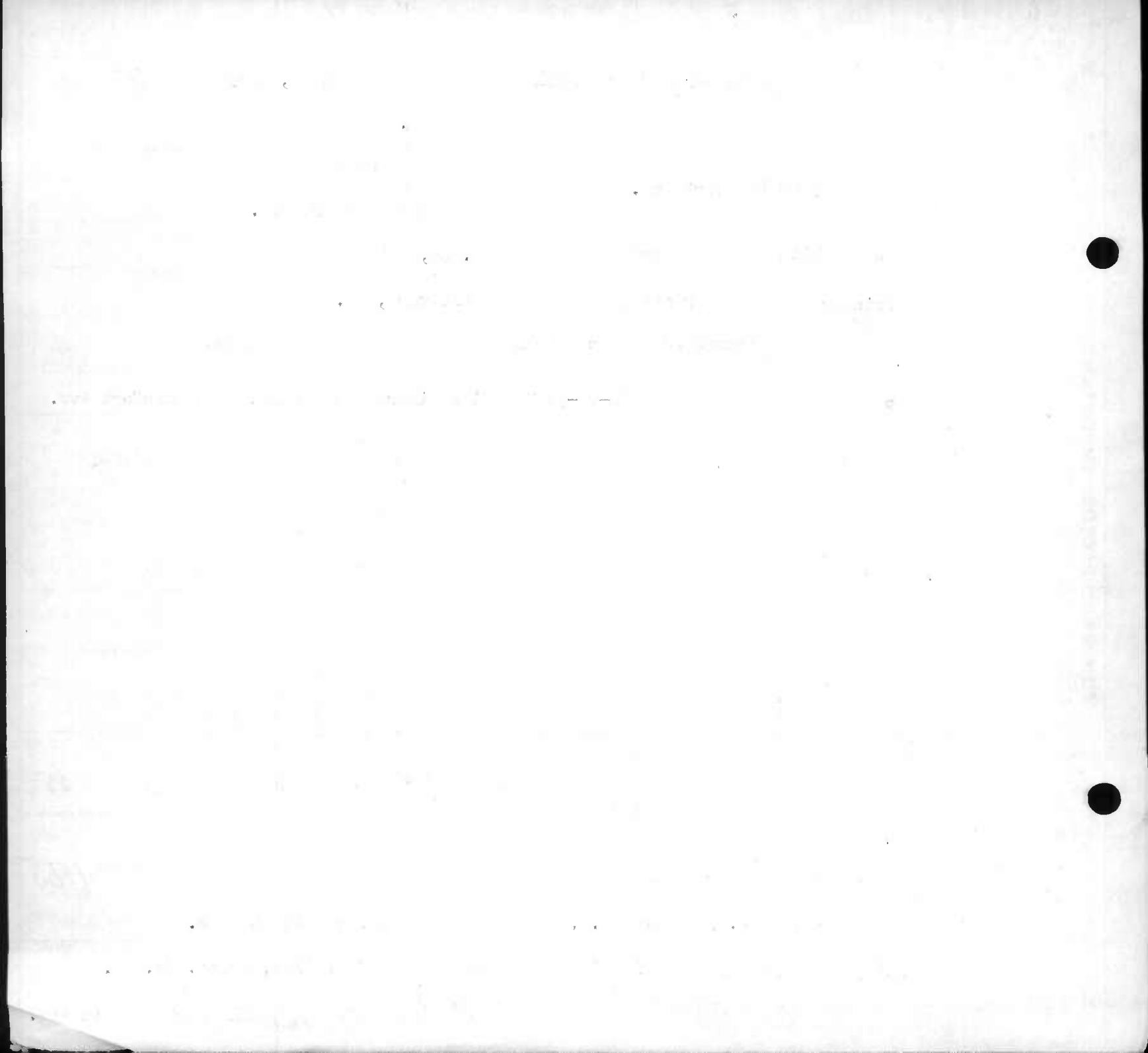
BIRTH NO. 65 4519				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4519	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Gladys E. Cunningham</i>				2. DATE AND HOUR OF DEATH <i>4/26/65 12:30 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hosp</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>27-14</i>	
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>4600 Wilmslow Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Div</i>		8. DATE OF BIRTH <i>10/10/02</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Florist</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Albert Ebaugh</i>				14. MOTHER'S MAIDEN NAME <i>Effie Cook</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-4690</i>		17. INFORMANT <i>Patient</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>170X I</i>				CAUSE OF DEATH (A) <i>Congestive heart failure</i> (B) <i>Anemia</i> (C) <i>Carcinoma of breast with pulmonary metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/14/65</i> 19 <i>65</i> to <i>4/26/65</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>4/26/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Miriam L. Cohen</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4/26/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MIRIAM L. COHEN</i>				23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-29-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Woodlaw Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Eugenia K. Seitz</i>		ADDRESS <i>5209 York Rd. Seitz Funeral Home Balto, Md. 21212</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 4520	
BIRTH NO. 65 4520		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Thomas Raymond McConnell		2. DATE AND HOUR OF DEATH April 26, 1965 6 <sup>05</sup> a. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  5009 Beaufort Ave.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2718 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5009 Beaufort Ave.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Aug. 29, 1879	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY Printing Shop		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Joseph McConnell				14. MOTHER'S MAIDEN NAME unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-3309		17. INFORMANT ADDRESS Miss Mildred McConnell, 5009 Beaufort Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) Coronary Thrombosis DUE TO (B) Arteriosclerotic Cardiovascular disease DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH 1 day							
19. ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-25 1965 to 4-26 1965, that (I) (we) last saw the deceased alive on 4-26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerome J. Blumberg M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-27-1965	
23C. PHYSICIAN'S NAME (Type) Jerome J. Blumberg, M.D.				23D. ADDRESS 4832 Park Heights Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/65		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR B. Vernon Lemmon		ADDRESS 4611 Park Heights Ave.	

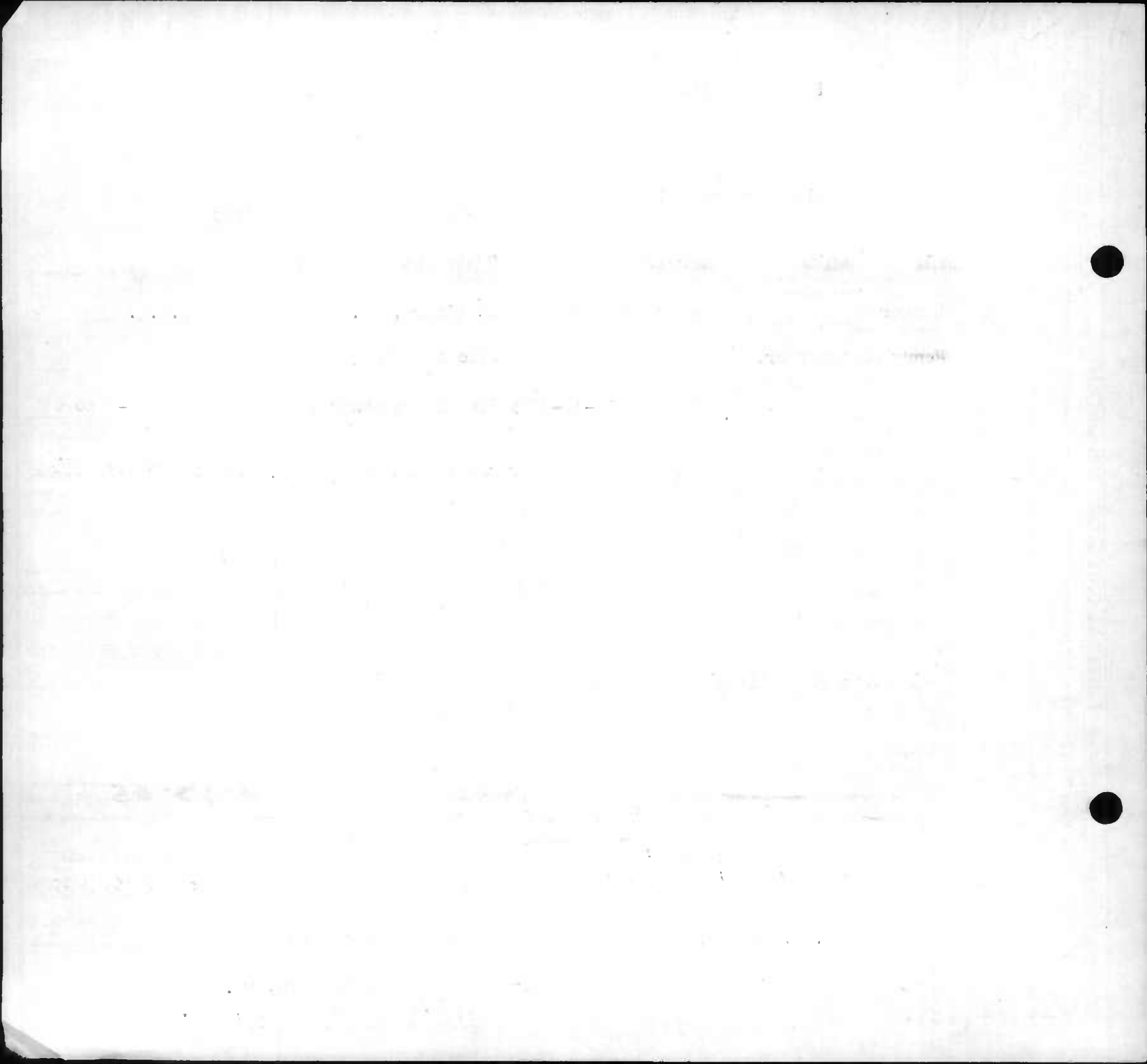




# FUNERAL DIRECTOR: IMPORTANT

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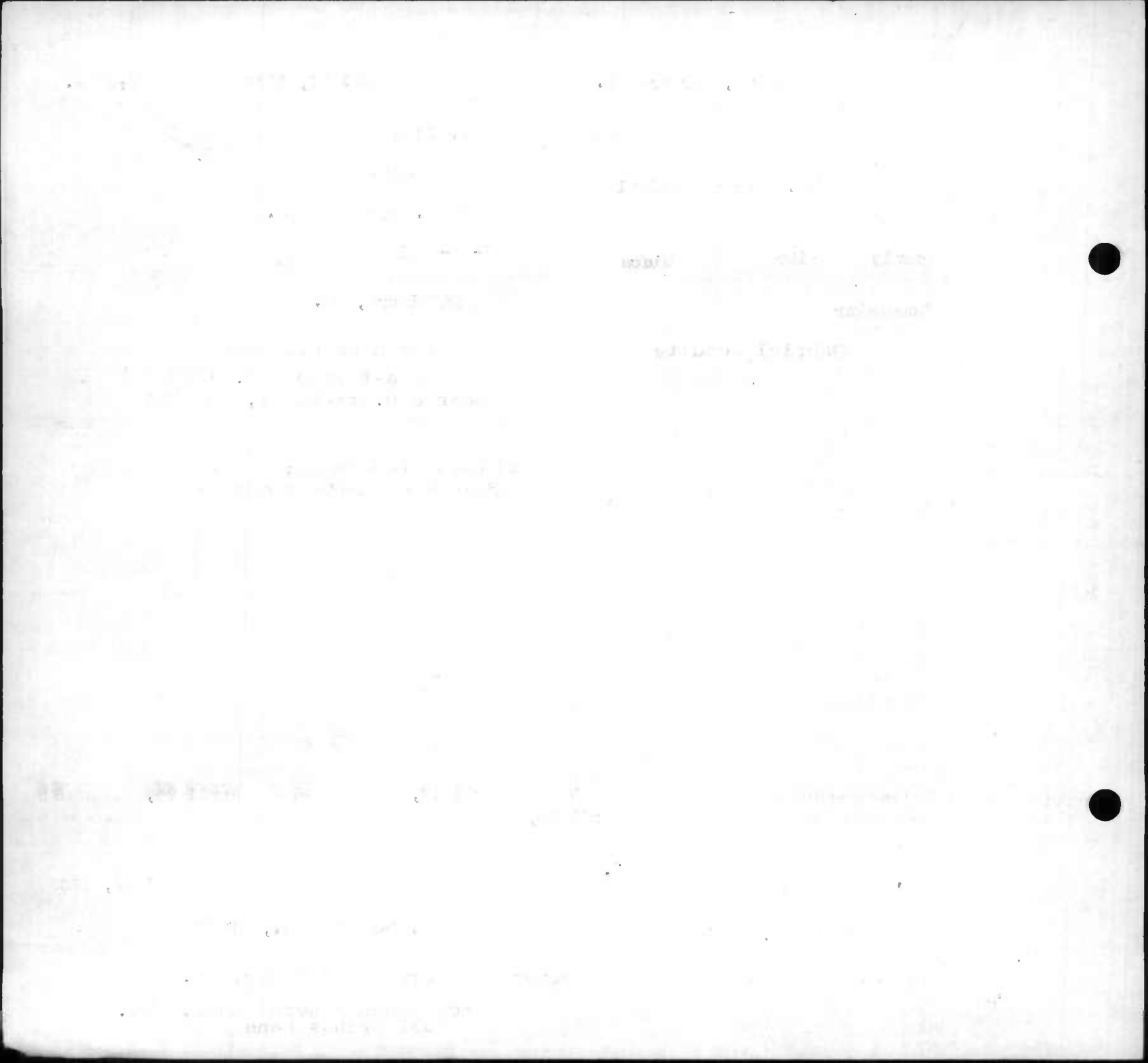
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="float: right;">65 4521</span>	
BIRTH NO. <span style="float: right;">65 4521</span>		M.E. CASE NO. <span style="float: right;">65 4521</span>		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OTTO HERMAN HUETTNER				APRIL 23, 1965 <span style="float: right;">M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  2713 Pelham Avenue #13				A. STATE <span style="float: right;">Maryland</span>			
				B. COUNTY <span style="float: right;">8-01</span>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="float: right;">2713 Pelham Avenue 21213</span>			
5. SEX <span style="float: right;">male</span>	6. RACE <span style="float: right;">white</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="float: right;">married</span>	8. DATE OF BIRTH <span style="float: right;">7/31/1905</span>	9. AGE (In years last birthday) <span style="float: right;">59</span>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">Checker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">Lever Brothers</span>		11. BIRTHPLACE (State or foreign country) <span style="float: right;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A.</span>	
13. FATHER'S NAME <span style="float: right;">Henry Huettner Sr.</span>				14. MOTHER'S MAIDEN NAME <span style="float: right;">Lizetta Hohn</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="float: right;">216-10-7275</span>		17. INFORMANT ADDRESS <span style="float: right;">Theresa Huettner (nee Novak) wife - above</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="float: right;">Carcinoma bronchus</span> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">4 Months</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="float: right;">2-15-45</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">neck Metastasis</span>		20A. AUTOPSY? (Yes or No) <span style="float: right;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="float: right;">1940</span> 19 to <span style="float: right;">4-23-45</span> 19, that (I) ( <del>we</del> ) last saw the deceased alive on <span style="float: right;">4-21-45</span> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <span style="float: right;">C. W. Peake</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">4-23-45</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">C. W. Peake</span>				23D. ADDRESS <span style="float: right;">4508 Harford Road</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">4/27/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Parkwood Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="float: right;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">APR 28 1965</span>		25B. NAME OF REGISTRAR <span style="float: right;">P. E. F. D. H. J.</span>		25C. FUNERAL DIRECTOR <span style="float: right;">Schimmes Funeral Home, Inc.</span>		ADDRESS <span style="float: right;">3331 Brenns Lane #13</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4522</u>	
BIRTH NO. <u>65 4522</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>Staab, Margaret L.</b>		<b>April 24, 1965</b>		<b>7:00 A.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
<b>St. Joseph Hospital</b>			<b>Maryland</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			<b>Baltimore #5</b>		
			D. STREET ADDRESS (If rural, give location)		
			<b>610 N. Lakewood Ave.</b>		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
<b>Female</b>	<b>White</b>	<b>Widow</b>	<b>1-29-1891</b>	<b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<b>Homemaker</b>				<b>Baltimore, Md.</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<b>Gabriel Schutte</b>			<b>Veronica Eichhorn</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS	
				<b>East Joppa Rd. 21128</b>	
				<b>George H. Staab, Jr., Box 29A</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
<p><b>170X I</b></p> <p><b>Carcinoma of left breast;</b></p> <p><b>widespread metastases of bone</b></p>			INTERVAL BETWEEN ONSET AND DEATH		
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<b>2</b>				<b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				<b>Yes</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 19,</b> 19 <b>65</b> to <b>April 24,</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 24,</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				<b>April 24, 1965</b>	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
<b>William B. VandeGrift</b>			<b>1400 N. Caroline St., 21213</b>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<b>Burial</b>		<b>4/27/65</b>		<b>Holy Redeemer Cemetery</b>	
				<b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR'S ADDRESS	
<b>APR 28 1965</b>		<b>Robert E. Farkas</b>		<b>Schimunek Funeral Home, Inc.</b>	
				<b>3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4523		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4523	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) (or JOHANNA) JENNIE SVITAK		2. DATE AND HOUR OF DEATH 4 24 65 110:15A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND			
ST AGNES HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21226			
		D. STREET ADDRESS (If rural, give location) 1527 LOCUST ST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED	8. DATE OF BIRTH 3 22 94	9. AGE (In years lost birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) CZECHOSLAVAKIA	
13. FATHER'S NAME THOMAS ZAMOSTNY		14. MOTHER'S MAIDEN NAME KATHRYN		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ST AGNES HOSP RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.14-260X		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Congestive Heart Failure			
ANTECEDENT CAUSES		(B) DUE TO Acute M.I.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes Mellitus			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4 15 19 65 to 4 24 65 19 that (I) (we) last saw the deceased alive on 4 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank M. Detorie		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/24/65	
23C. PHYSICIAN'S NAME (Type) FRANK M. DETORIE		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/65		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR Robert E. Farley M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	

1944-1945  
1946-1947

2000 - 1944

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961



1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

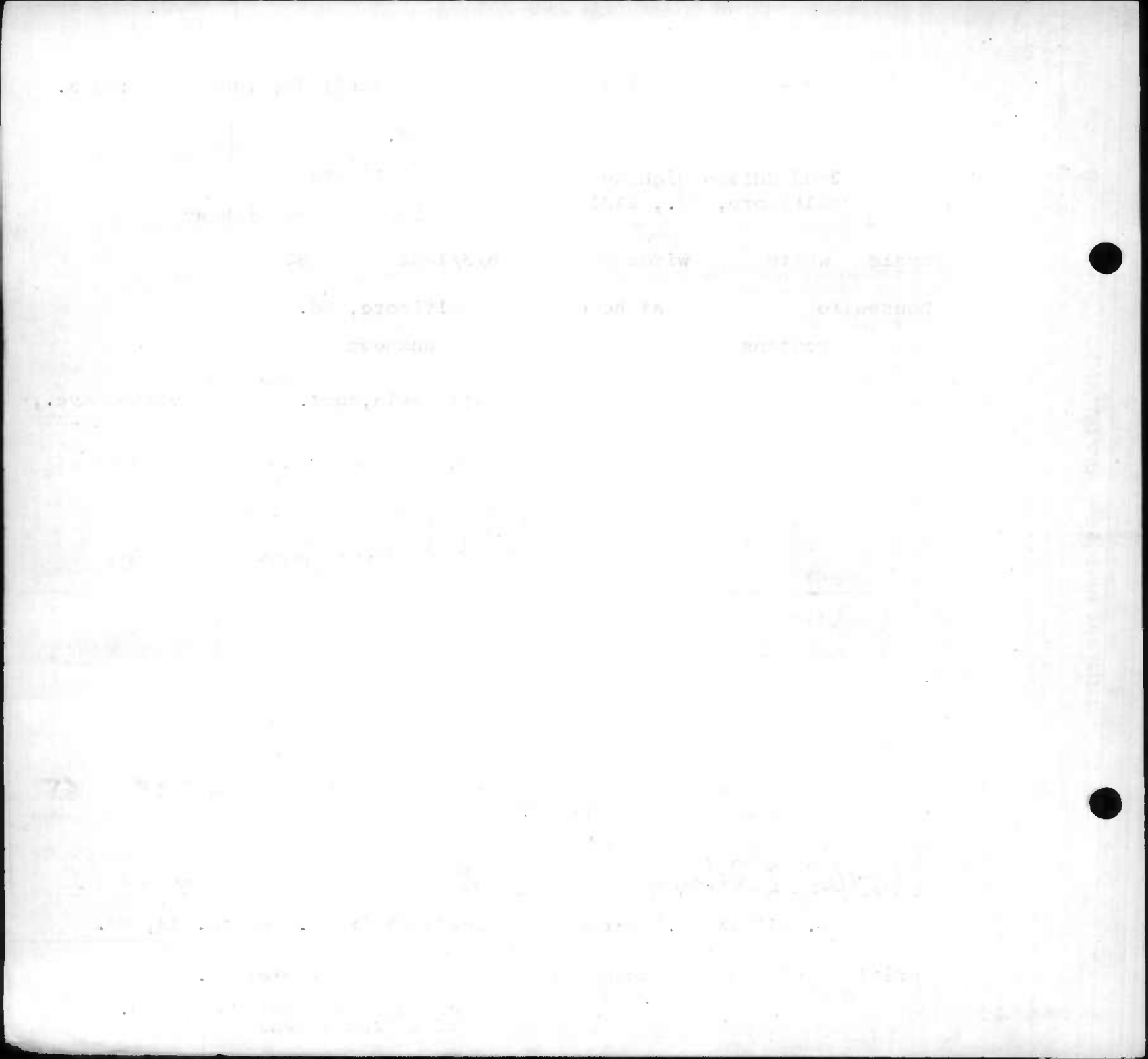
1972-1973

1974-1975

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4524				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4524	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ADA CATHERINE MEYER</b>				2. DATE AND HOUR OF DEATH <b>April 24, 1965 1:30 a. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2803 Edison Highway Baltimore, Md., 21213</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2803 Edison Highway</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>6/3/1882</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Peutens</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Zone 15 Ruth Levin, dght. 5615 Groveland Ave.,</b>		
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Symptomatic of heart failure with toxicosis</b> DUE TO (B) <b>Hypertension arteriosclerotic</b> DUE TO (C) <b>Heart Disease - Gen</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>June 15 1960</b> to <b>April 24 1965</b> , that (I) (we) last saw the deceased alive on <b>April 19 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William L. Fearing</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. William L. Fearing</b> M.D.				23D. ADDRESS <b>3025 Belair Rd., Balto. 13, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/26/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fearing</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	

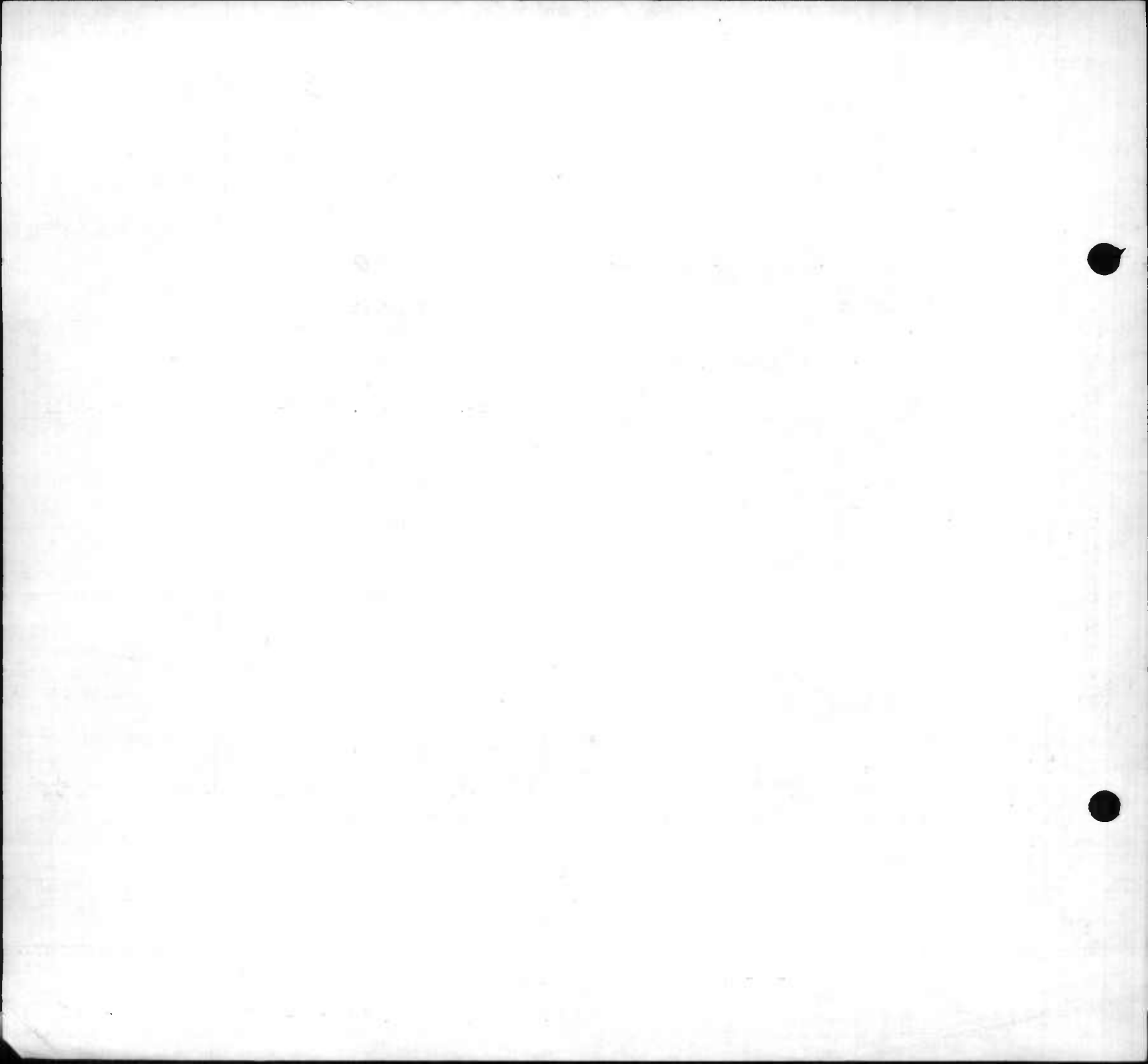




# FUNERAL DIRECTOR: IMPORTANT

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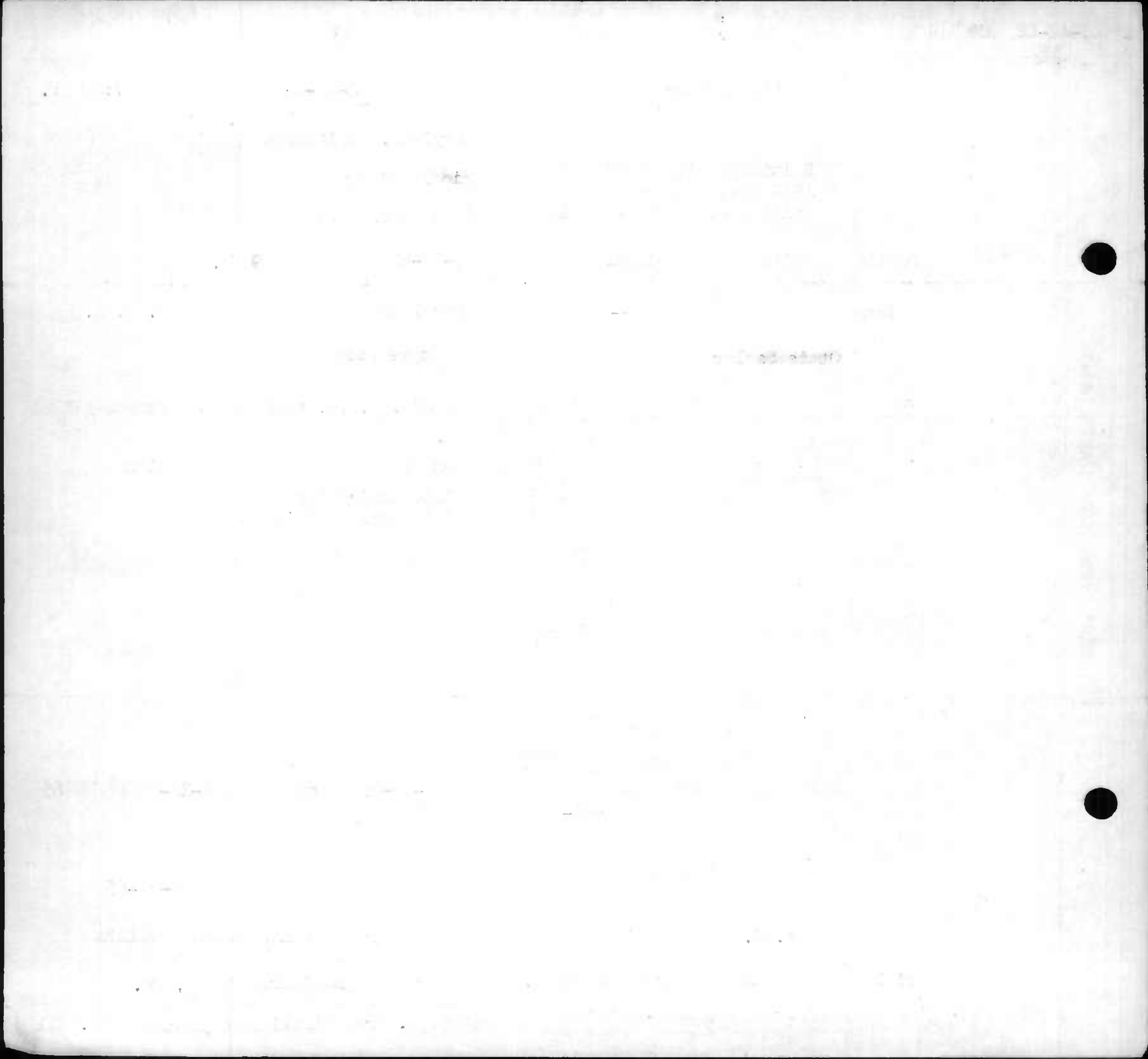
BALTIMORE CITY HEALTH DEPARTMENT									
65 4525					CERTIFICATE OF DEATH				
BIRTH NO.					Registered No. 65 4525				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Rodenberg, Bertha</u>					4/24/65 4pm. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>					A. STATE <u>md.</u> B. COUNTY <u>28-04</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto. 29.</u>				
					D. STREET ADDRESS (If rural, give location) <u>107 Westowne Rd.</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W.</u>	8. DATE OF BIRTH <u>10-17-90</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Thomas Parkinson</u>					14. MOTHER'S MAIDEN NAME <u>unknown Abegale -</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Louise E. Gaver-1 Mallow Hill Rd.-21229</u>				
18. <u>330X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Sub arachnoid hemorrhage</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) <u>Arterio-sclerosis</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>4-23-</u> 19 <u>65</u> to <u>4/24</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.									
23A. SIGNATURE <u>Octavio A. Ruiz</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4/24</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Octavio A. Ruiz</u>					23D. ADDRESS <u>M.D.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-27-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard-4107 Wilkens Ave-21229</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 4528</b>				65 4528	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<b>Lisa Sadler</b>			<b>4-24-65 7:20 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			A. STATE <b>Maryland, Baltimore</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Middle River</b> D. STREET ADDRESS (If rural, give location) <b>18 Henderson Road #21220</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>9-11-63</b>	9. AGE (In years lost birthday) <b>19 Mo.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Ottis Sadler</b>			14. MOTHER'S MAIDEN NAME <b>Joyce Moss</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>		
18. <b>087X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <b>Chicken Pox with Salicylate Intoxication with Possible Aspiration Pneumonia with Possible Encephalitis</b>		
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4-24-65</b> 19 <b>65</b> to <b>4-24-</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-24-</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Wayne Klein</b>			23B. DATE SIGNED <b>4-24-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Dr. S. Wayne Klein</b>			23D. ADDRESS <b>4940 Eastern Avenue #21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/28/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. F...</b>		25C. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>	
				ADDRESS <b>1407 Eastern Ave. #21</b>	



BIRTH NO. 65 452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>SYLVAN KATZ</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>4-25-65 12:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL - DOA</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>12-02</b> D. STREET ADDRESS (If rural, give location) <b>201 E. University Parkway</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-2-1898</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>BENJAMIN</b>			14. MOTHER'S MAIDEN NAME <b>LING</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>			16. SOCIAL SECURITY NO. <b>212-03-5717</b>	17. INFORMANT ADDRESS <b>Hospt RECORDS</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>422.1</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b> DATE SIGNED <b>4-26-65</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>4/28/1965</b>	23C. NAME OF CEMETERY or CREMATORY <b>HEBREW FRIENDSHIP</b>		23D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>		
24A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		24C. FUNERAL DIRECTOR <b>SYLVAN S. LEWIS &amp; SON, INC.</b> ADDRESS <b>3319 OLYMPIA AVE</b>			

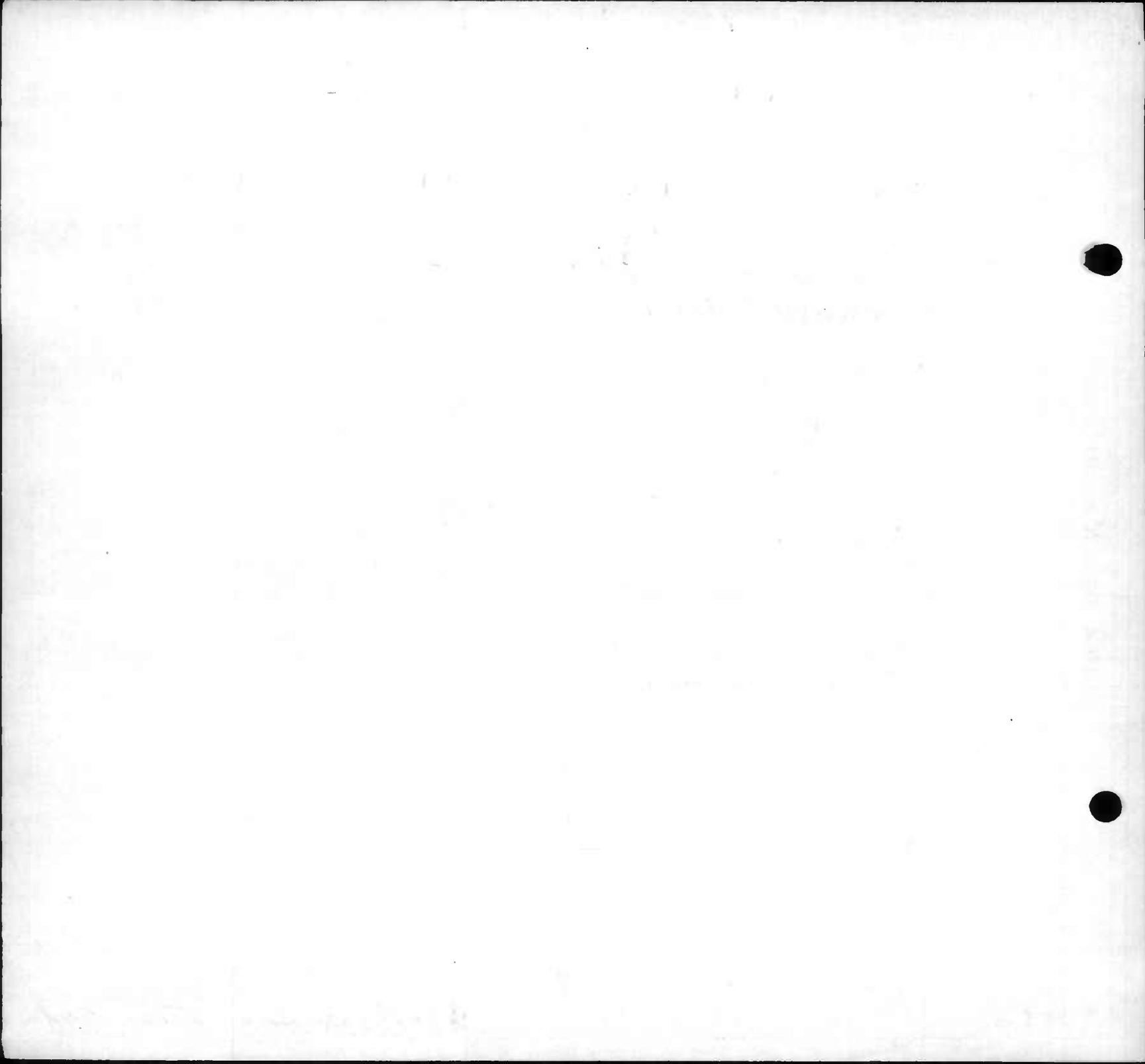
WALDEY FORDS

WALDEY FORDS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4528		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4528	
1. NAME OF DECEASED (Type or Print) <b>HANLEY, RICHARD F. S.</b>			2. DATE AND HOUR OF DEATH <b>4-24-65</b> <b>9:35AM</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 4 - TOWSON</b> D. STREET ADDRESS (If rural, give location) <b>604 CENTRAL AVENUE 53-00</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>1-5-96</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months: Days 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES REPRESENTATIVE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY EQUIPMENT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>RICHARD HANLEY</b>			14. MOTHER'S MAIDEN NAME <b>MARY PADIAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FAMILY RECORDS</b>	
18. <b>4528X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> <b>?? Myocardial infarction</b> <b>or ?? Acute Pulmonary Embolus</b> INTERVAL BETWEEN ONSET AND DEATH <b>0</b>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Ruptured Aneurysmorrhaphy</b>					
19A. DATE OF OPERATION <b>3 4/18/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> 19 <b>65</b> to <b>4/24</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/24</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David Goldfarb</b>			23B. DATE SIGNED <b>4/24/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>DAVID GOLDFARB</b>			23D. ADDRESS <b>Johns Hopkins Hosp., Balto, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>APR 27, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. MARIA CEMETERY</b>	
24D. LOCATION <b>TOWSON, MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		24F. NAME OF REGISTRAR <b>John Burns' Sons, Towson, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>John Burns' Sons, Towson, Md.</b>		25C. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Md.</b>	

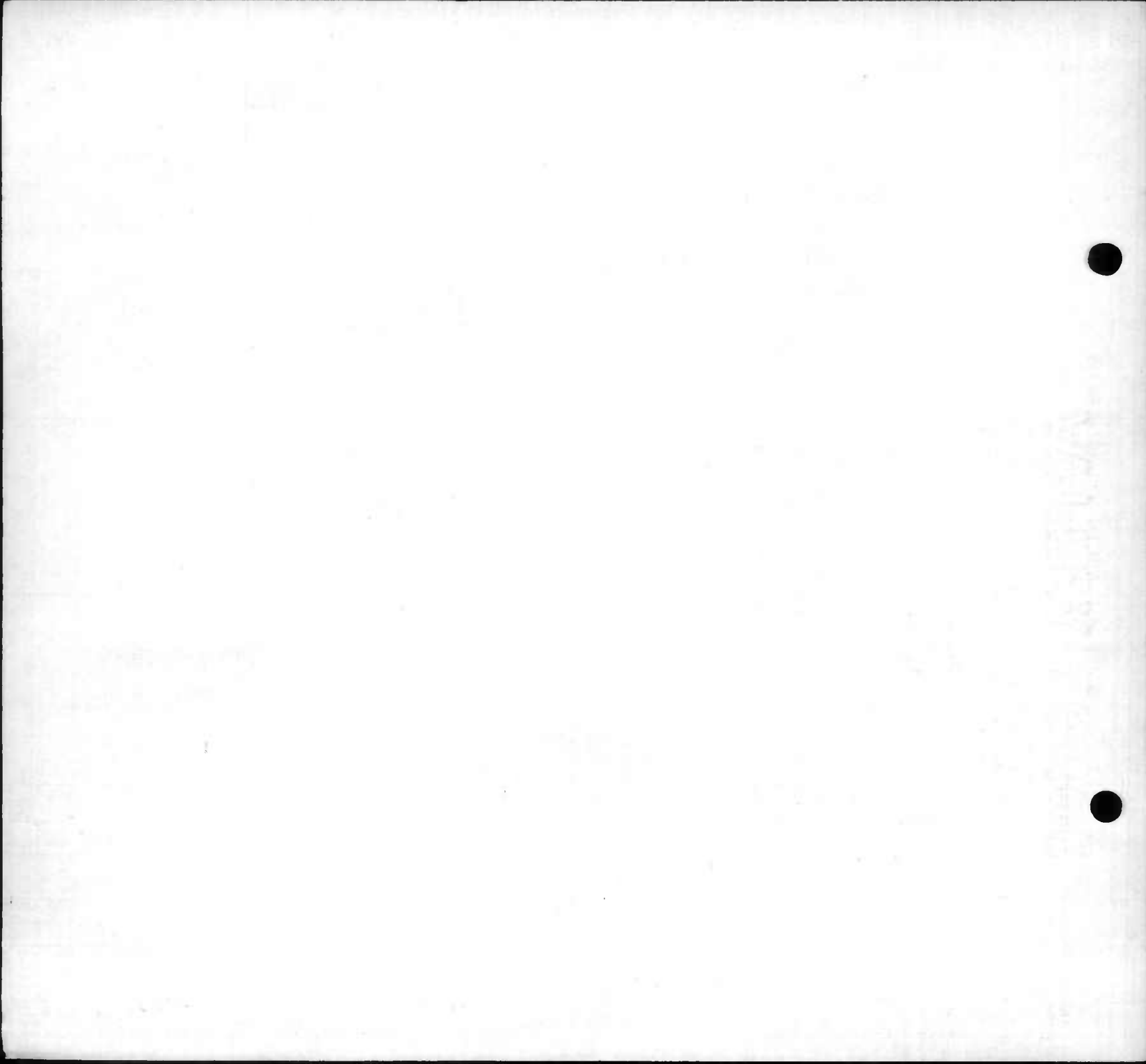




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

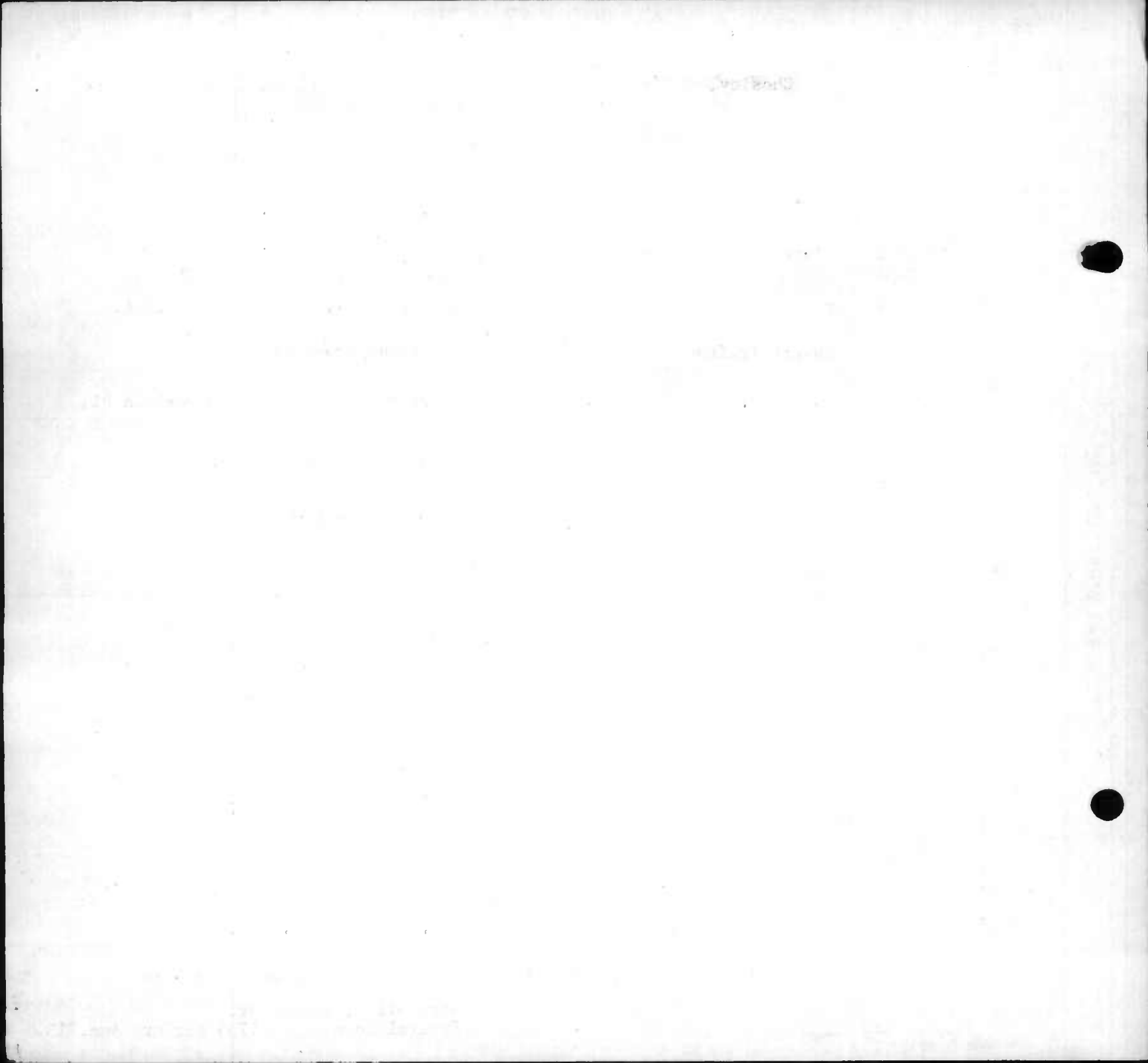
BIRTH NO. <span style="font-size: 24pt;">65 4529</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 24pt;">65 4529</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <span style="font-size: 18pt;">Mrs. Florence Barbi</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 18pt;">APRIL 25, 1965 5:45 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 18pt;">Bon Secours Hospital</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 18pt;">MD</span> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 18pt;">BALTIMORE 21228</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 18pt;">2024 Northurst Way 53-61</span>		
5. SEX <span style="font-size: 18pt;">FE</span>	6. RACE <span style="font-size: 18pt;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 18pt;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 18pt;">8/10/25</span>	9. AGE (In years last birthday) <span style="font-size: 18pt;">39</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 18pt;">Penna.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 18pt;">USA</span>
13. FATHER'S NAME <span style="font-size: 18pt;">Henry Morrison</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 18pt;">JOSEPHINE BATULIS</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
18. <span style="font-size: 18pt;">587.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 24pt;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <span style="font-size: 18pt;">Hepatic Cirrhosis</span> DUE TO (B) <span style="font-size: 18pt;">Hepatic Insufficiency</span> DUE TO (C) <span style="font-size: 18pt;">Terminal Bronchopneumonia</span>		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 18pt;">4-19</span> 1965 to <span style="font-size: 18pt;">4-25</span> 1965, that (I) (we) last saw the deceased alive on <span style="font-size: 18pt;">4-25</span> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 18pt;">E. S. MacDuff</span>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 18pt;">4-25-65</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 18pt;">E. S. LINANTUD, JR.</span>			23D. ADDRESS <span style="font-size: 18pt;">Bon Secours Hospital</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 18pt;">Burial</span>	24B. DATE <span style="font-size: 18pt;">4/28/1965</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 18pt;">Lake View Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 18pt;">Liberty Road - Carroll Co. - Md</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 18pt;">APR 28 1965</span>	25B. NAME OF REGISTRAR <span style="font-size: 18pt;">Robert E. Fisher, M.D.</span>	25C. FUNERAL DIRECTOR <span style="font-size: 18pt;">E. S. MacDuff</span>		ADDRESS <span style="font-size: 18pt;">3017 Frederick 21228</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 4530</span>	
BIRTH NO. <span style="float: right;">65 4530</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Chesley, Sadie		April 24, 1965 7:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  St. Joseph Hospital			A. STATE Maryland		
			B. COUNTY 12-05		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #2		
			D. STREET ADDRESS (If rural, give location) 315 E. Lafayette Ave.		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH April 27, 1912	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland	
13. FATHER'S NAME Robert Trafton			14. MOTHER'S MAIDEN NAME Irene Cromwell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Chesley 1928 Perlman Pl.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
			(A) Diabetes Mellitus with acidosis DUE TO		
			(B) Congestive heart Failure DUE TO		
			(C) Anemia DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 23 19 65 to April 24 19 65, that (I) (we) last saw the deceased alive on April 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Viriyapongse				23B. DATE SIGNED April 24, 1965	
23C. PHYSICIAN'S NAME (Type) Sukho Viriyapongse			23D. ADDRESS 1400 N. Caroline St., 21213		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-29-65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr. Funeral Home 1735 Harford Ave. #13	



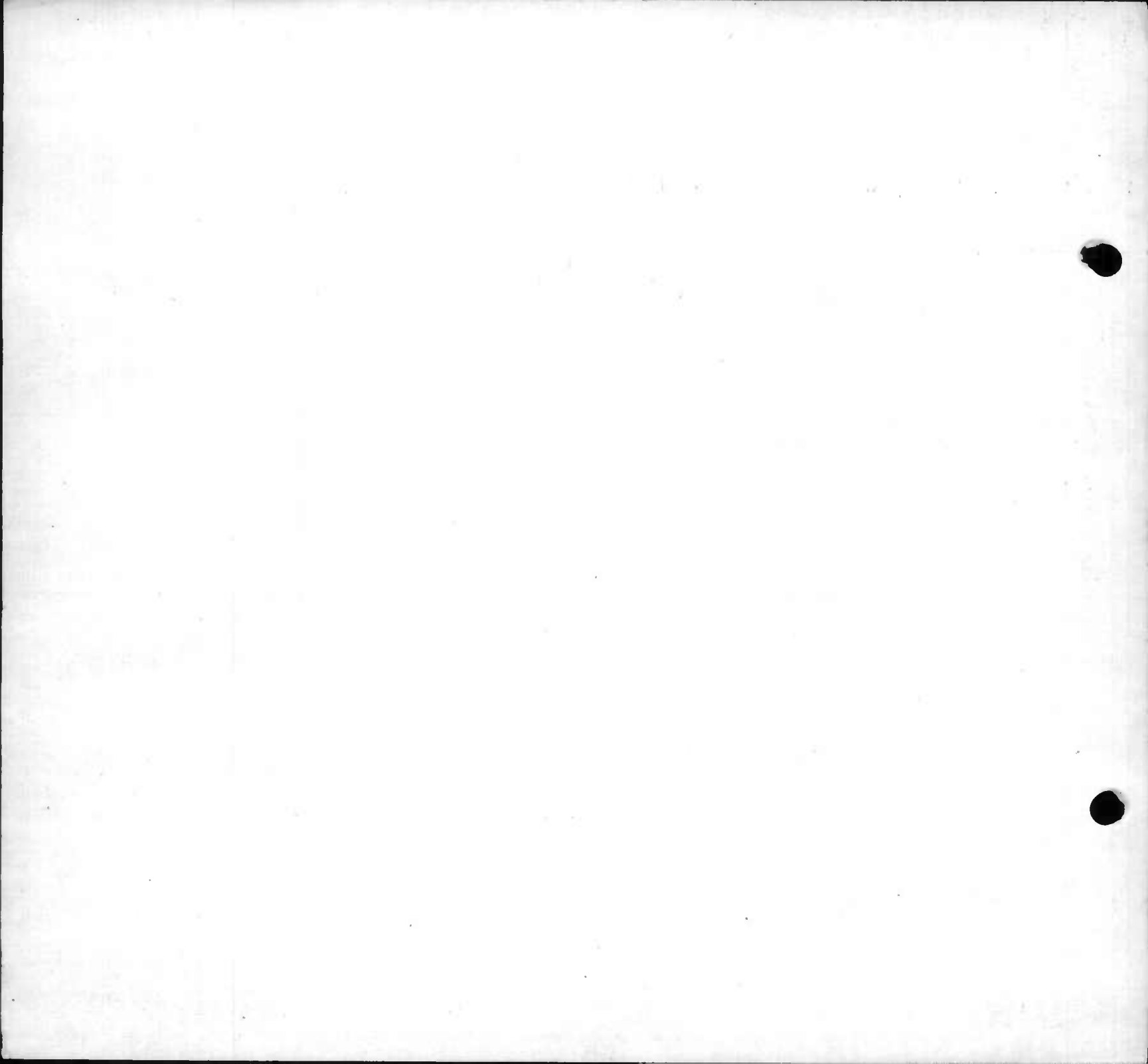
RELEASED AS NON-MEDICAL BY DR. ADAMS

M. E. Rowse

Funeral Director: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

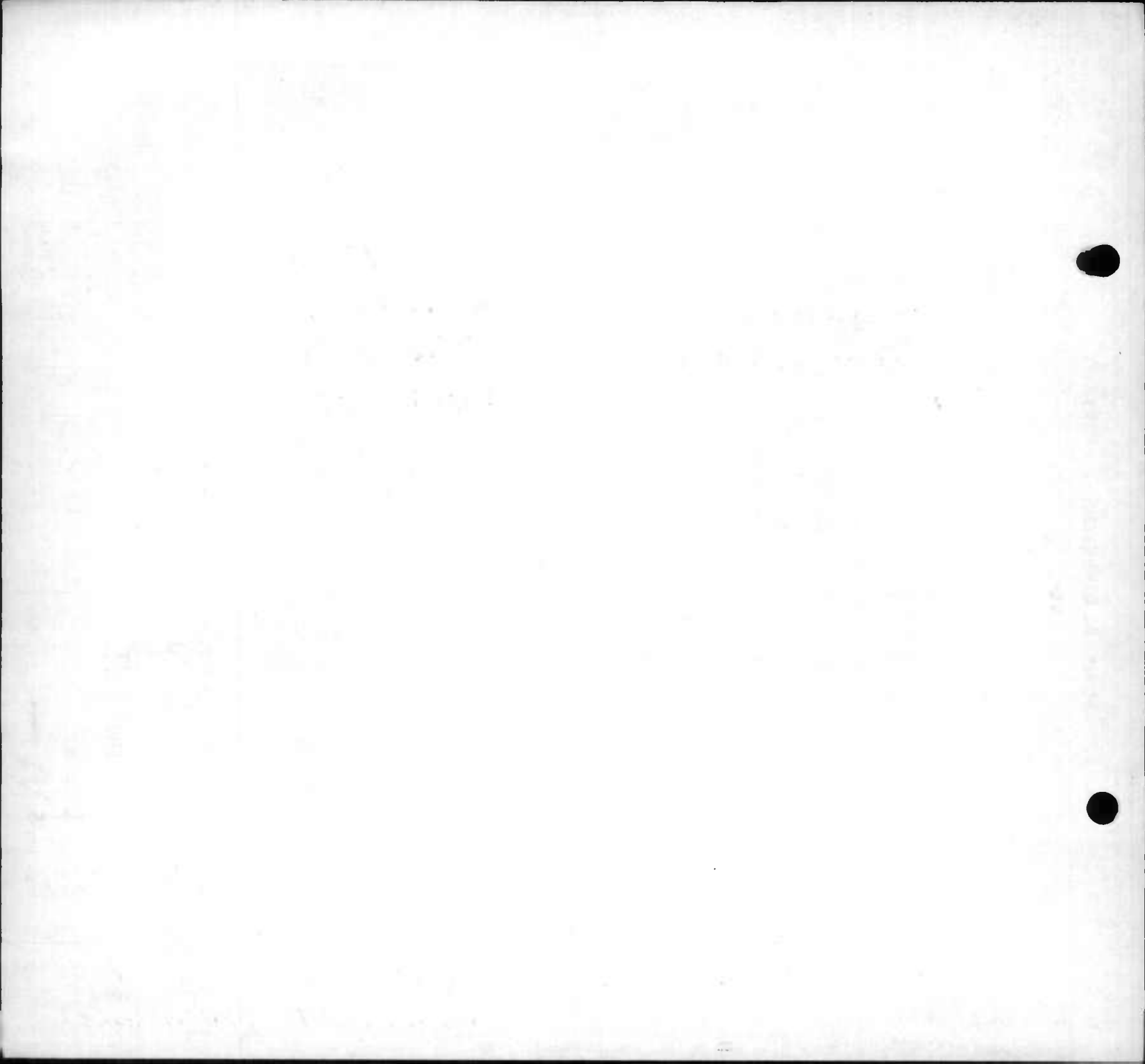
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
6103205 65 4531		CERTIFICATE OF DEATH		65 4531	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EVELYN YORK		24 APRIL 1965 11:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSPITAL		MARYLAND BALTIMORE			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		BALTIMORE 9-09			
		D. STREET ADDRESS (If rural, give location)			
		1422 HARFORD AVE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	N	NEVER MARRIED	FEB. 7/1961	4	None
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				BALTIMORE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ALBERT YORK		IDA JONES LEGGITT		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		NONE		MOTHER	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		SHOCK			
		(C) DUE TO			
		MENINGOCOCCEMIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 24 APRIL 1965 to 24 APRIL 1965, that (I) (we) lost saw the deceased alive on 24 APRIL 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
JOHN C ROWSE				24 APRIL 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN ROWSE		JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4-28-65		MT. CALVARY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 28 1965		Robert E. Farkner		MARSHALL W. JONES, JR.	
				ADDRESS 1735 HARFORD AVE.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4532				
BIRTH NO. 65 4532									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>FREDERICK A. SCOTT</b>					2. DATE AND HOUR OF DEATH <b>April 27, 1965 2:35 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b> <b>42 OF BALTIMORE</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>15-10</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>				
					D. STREET ADDRESS (If rural, give location) <b>3903 CHATHAM RD.</b>				
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-19-13</b>	9. AGE (In years last birthday) <b>52</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UN EMPLOYED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Williamsburg, VA</b>			12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George Scott</b>					14. MOTHER'S MAIDEN NAME <b>Blanche Gregory</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edith M. Scott</b>			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>420.1X1260X</b> <b>Acute Myocardial Infarct</b> <b>ASCVD</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>10 yrs +</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4/27 1965</b> to <b>4/27 1965</b> , that (I) (we) last saw the deceased alive on <b>4/27 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Samuel M. Muter</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4/27/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>SAMUEL MUTER</b>					23D. ADDRESS M.D. <b>SINAI HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-1-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus</b>			24D. LOCATION (City, town, or county) (State) <b>Arbutus Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Morton + Dyett</b>			ADDRESS <b>1701 Laurens St.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4533</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4533</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Edna Floyd</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4-26-65</span> <span style="font-size: 1.2em;">3:24</span> p. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">608 W. Biddle Street</span>				A. STATE <span style="font-size: 1.2em;">Maryland</span>			
				B. COUNTY <span style="font-size: 1.2em;">608 W. Biddle St</span>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">17-01</span> <span style="font-size: 1.2em;">Maryland</span>			
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Single</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1-13-1896</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">69</span>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">William Floyd</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Rachel Williams</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">B. Cotrell</span>		ADDRESS <span style="font-size: 1.2em;">718 Wilmer Court</span>	
18. <span style="font-size: 1.2em;">443X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Pulmonary Edema</span> DUE TO (B) <span style="font-size: 1.2em;">Congestive Heart Failure</span> DUE TO (C) <span style="font-size: 1.2em;">M.A.S.C.U.D</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3-4 days</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 25</span> , 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">April 26</span> , 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">April 26</span> , 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Robert C. Blackmon</span> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/27/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert C. Blackmon</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">255 N. Payson St. Balt. Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-29-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Auburn</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 28 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">MORTON &amp; DYETT</span>		ADDRESS <span style="font-size: 1.2em;">1701 Laurens Street</span>	

Robert C. Blackman

BIRTH NO.

65 4534

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4534

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HILLIARD JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1965 9:20 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1023 Warden Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

3-10-25

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Waynesboro, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Arthur Walker

14. MOTHER'S MAIDEN NAME

Lillie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW 11 33734991

16. SOCIAL  
SECURITY NO.

212-28-4217

17. INFORMANT

ADDRESS

Vena Jackson 1023 Warden St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) DUE TO Hypertensive and arteriosclerotic  
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-27-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-30-65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 28 1965

24B. NAME OF REGISTRAR

Robert E. Felt

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

Funeral Home 1735-37 Harford Avenue

VALLEY FORGE

WILLIAM J. BROWN

Wanted

Wanted, J.C.

Account Wanted

Wanted, J.C.

Wanted, J.C.

Wanted, J.C.

Wanted, J.C.

Wanted, J.C.

Wanted, J.C.

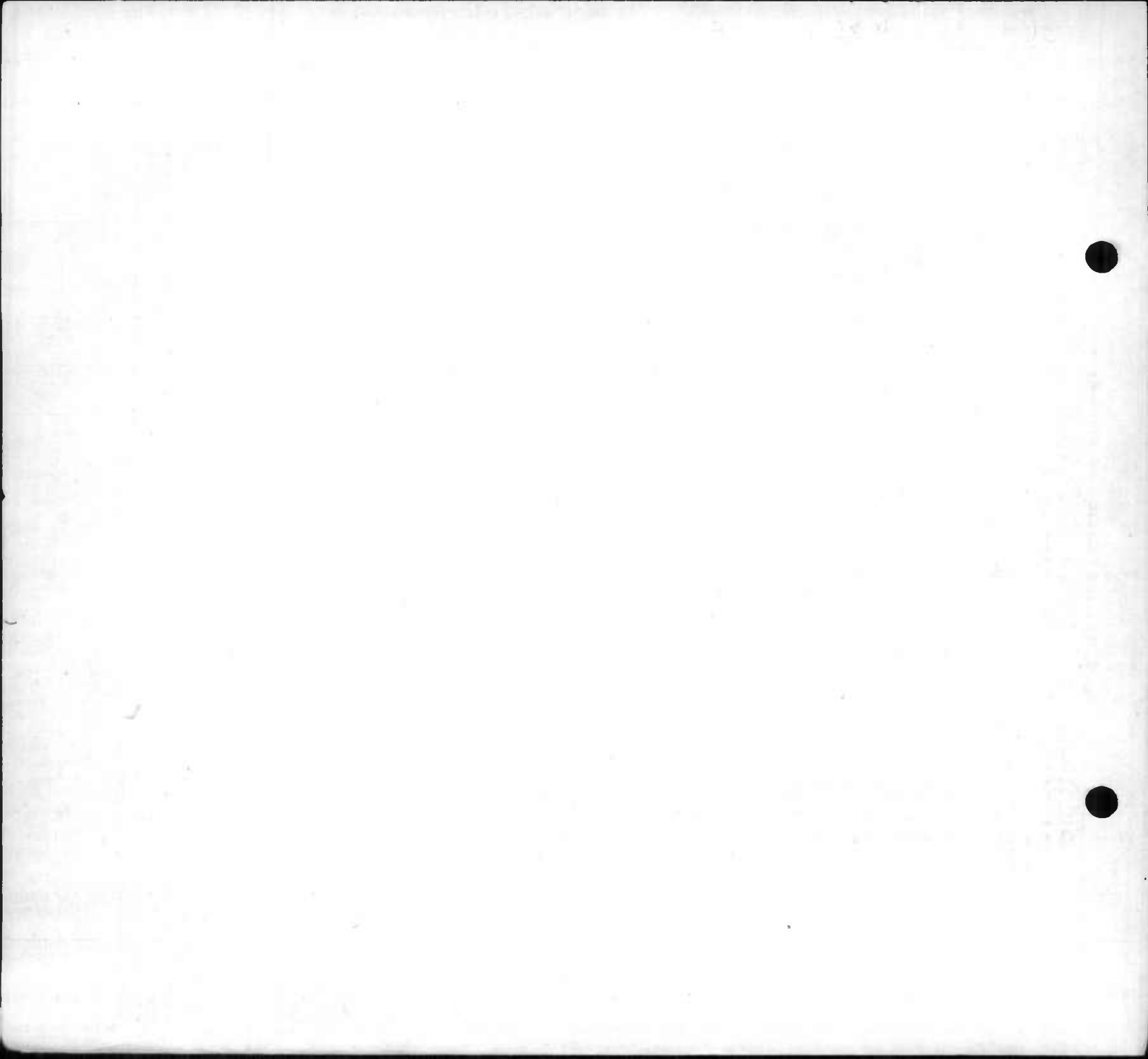
Wanted, J.C.

Wanted, J.C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

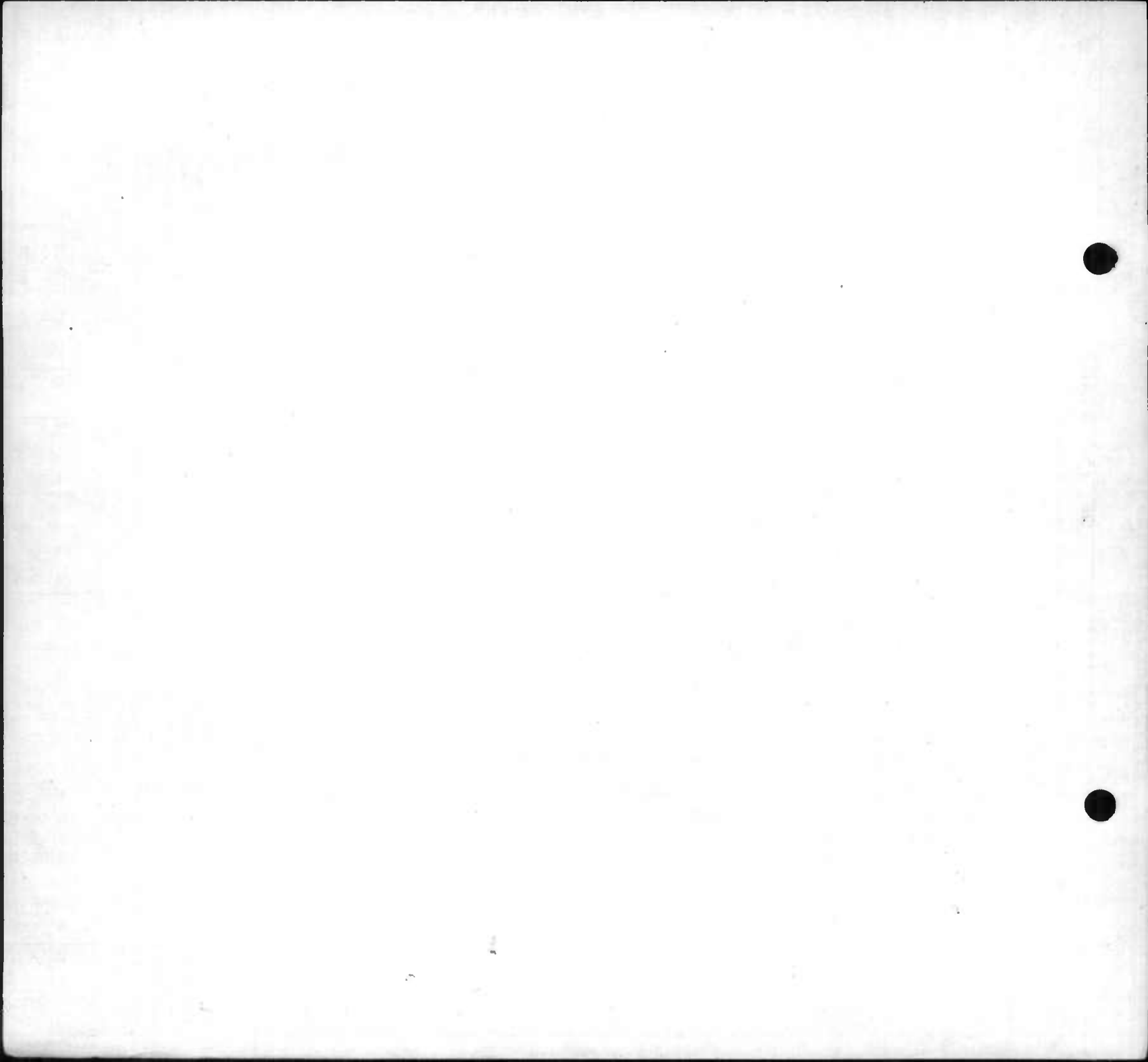
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.
BIRTH NO. <u>6508692</u>		65 4535		65 4535
M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>HARRY BABY GIRL</u>			2. DATE AND HOUR OF DEATH <u>4-3-65</u> <u>1:53</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF INSTITUTION <u>UNIVERSITY</u>			A. STATE <u>MARYLAND</u>	
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
			D. STREET ADDRESS (If rural, give location) <u>734 W. FAYETTE ST.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>—</u>	8. DATE OF BIRTH <u>4-1-65</u>	9. AGE (In years last birthday) <u>1</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>WILLIAM HARRY</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>	
			17. INFORMANT ADDRESS <u>HOSPITAL RECORD</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>IMMATURITY</u> <u>BW - 762 gms.</u>			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-1-1965</u> to <u>4-3-1965</u> , that (I) (we) last saw the deceased alive on <u>4-3-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death.				
23A. SIGNATURE <u>J. L. Baker</u>			23B. DATE SIGNED <u>4-3-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Baker</u>			23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>APR 26 1965</u>		24B. DATE <u>APR 26 1965</u>		
24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town or county) (State) <u>UNIVERSITY MEDICAL SCHOOL</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="float: right;">65 4536</span>	
BIRTH NO. <span style="float: right;">65 4536</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				WILLIAMS BABY BOY A		4-17-65 8:00 PM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
UNIVERSITY HOSPITAL				MARYLAND			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				532 LAURENS ST #17			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
M	C		4-17-65			5 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					MARYLAND		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
WILLIAM JENKINS				DIANE WILLIAMS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
					HOSP RECORD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
776X I				IMMATURITY (B.W. 723gms)			
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-17-65 to 4-17-65, that (I) (we) last saw the deceased alive on 4-17-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. Fred Baker						4-17-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. Fred Baker							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
		APR 26 1965		UNIVERSITY MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 28 1965		Robert E. Fairbank		MORTUARY SERVICE - BCD			

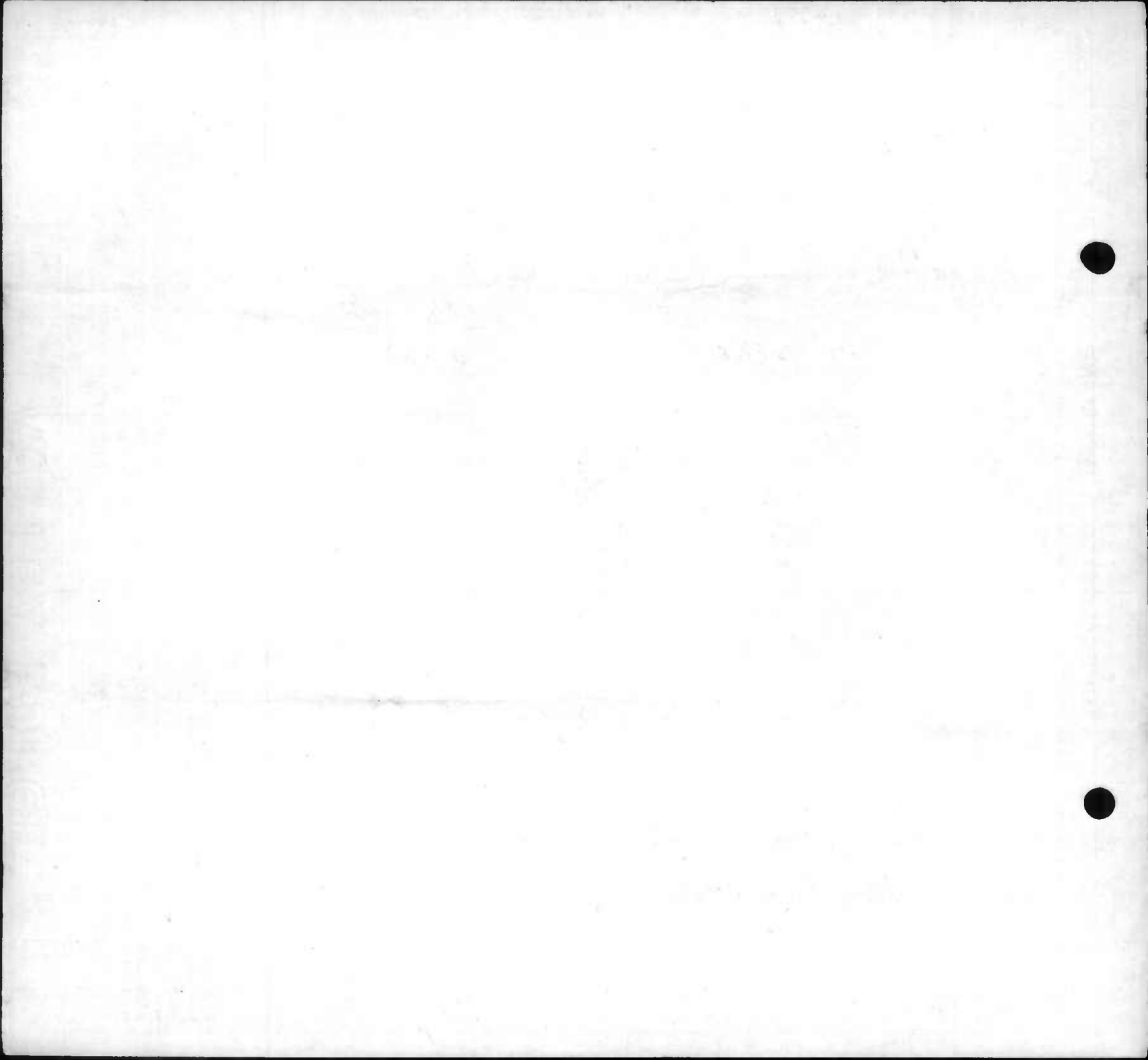




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

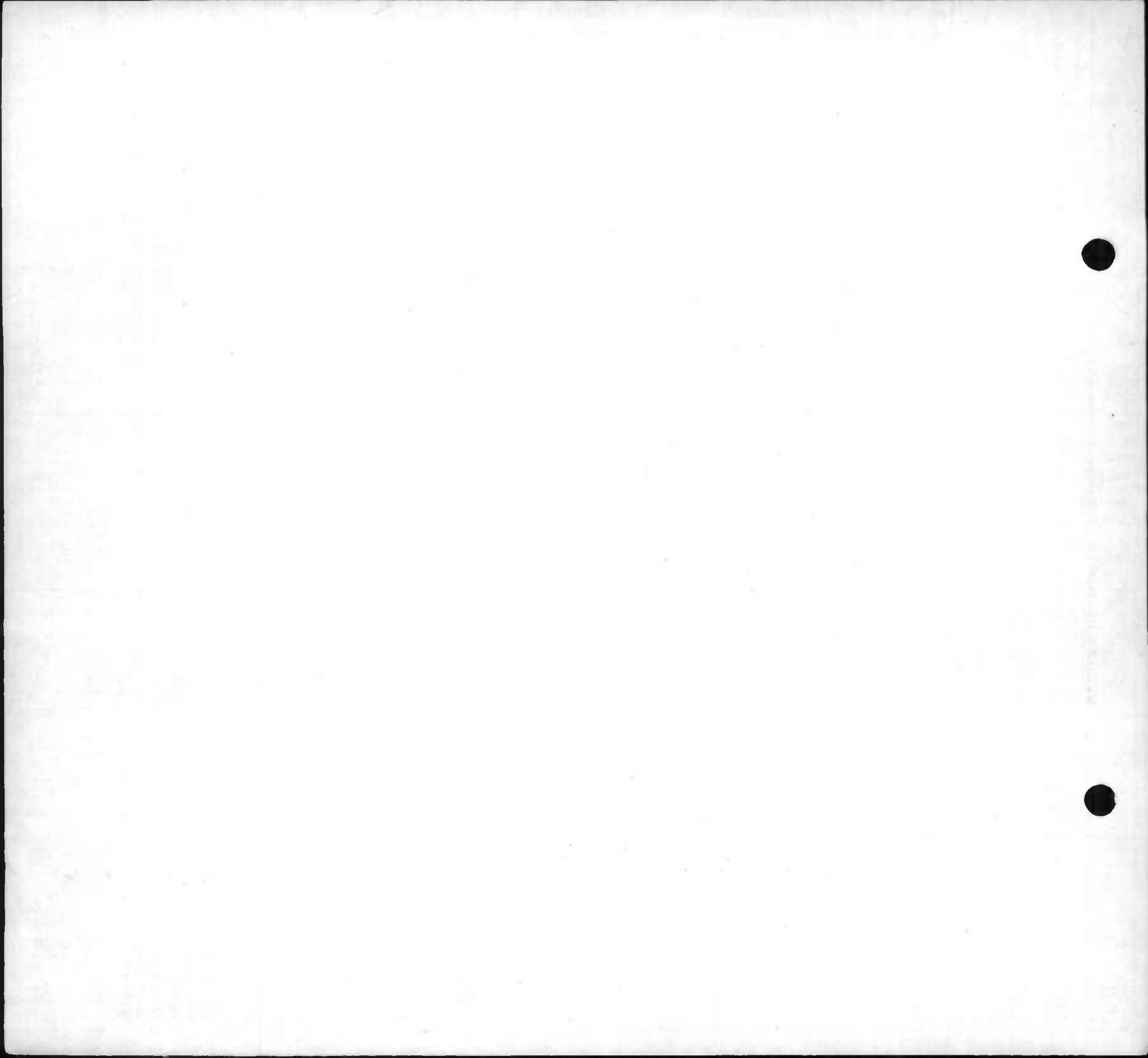
BIRTH NO. 65-09912 65 4537				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4537 4	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) WILLIAMS BABY BOY B		2. DATE AND HOUR OF DEATH 4-17-65 8:00 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					
				D. STREET ADDRESS (If rural, give location) 532 LAURENS ST #17					
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 4-17-65	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM JENKINS				14. MOTHER'S MAIDEN NAME DIANE WILLIAMS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSP RECORD			
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) IMMATUREITY (B.W. 723 gms)				INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-12-1965 to 4-17-1965, that (I) (we) last saw the deceased alive on 4-17-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Fred Baker				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 4-17-65	
23C. PHYSICIAN'S NAME (Type) J. FRED BAKER				23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE APR 26 1965		24C. NAME OF CEMETERY OR CREMATORY 6 E C		24D. LOCATION (City, town or County) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4538	
BIRTH NO. 65 4538		M.E. CASE NO.		4	
1. NAME OF DECEASED (Type or Print) <i>BABY BOY MOORE</i>			2. DATE AND HOUR OF DEATH <i>APRIL 19 1965 3:00 P.M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			A. STATE <i>MARYLAND</i>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>		
			D. STREET ADDRESS (If rural, give location) <i>867 W. Lexington St.</i>		
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>APRIL 18 1965</i>	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>			11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>UNKNOWN</i>			14. MOTHER'S MAIDEN NAME <i>SHIRLEY MOORE</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <i>776 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>IMMATURITY</i> DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(X)</i> (this hospital) attended the deceased from <i>APRIL 18 1965</i> to <i>APRIL 19 1965</i> , that <i>(X)</i> (we) last saw the deceased alive on <i>APRIL 19 1965</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(X)</i> (We) (did) <i>(did not)</i> view the body after death.					
23A. SIGNATURE <i>Kenneth E. Mott</i>				23B. DATE SIGNED <i>April 19 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>KENNETH E. MOTT</i>				23D. ADDRESS <i>ANATOMY BOARD OF MARYLAND</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>APR 26 1965</i>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farley</i>	
25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>		25D. ADDRESS			



65 4539 CERTIFICATE OF DEATH

Registered No. 65 4539

BIRTH NO. 6508231

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

BABY GIRL THOMAS

2. DATE AND HOUR OF DEATH

27 March 1965 3 A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

948 Harlem Avenue

5. SEX

F

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

26 Mar 65

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.

1 24

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Lillie Thomas

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital record

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) \_\_\_\_\_  
DUE TO

immaturity

(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

None

20A. AUTOPSY? (Yes or No)

YES NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 26 Mar 1965 to 27 Mar 19 65.  
that (I) (we) lost saw the deceased alive on 26 Mar 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Russell J. Bunai Jr.

M.D.

Attending  
Phys.Med.  
DirectorStoff  
Phys.

23B. DATE SIGNED

27 Mar 65

23C. PHYSICIAN'S  
NAME (Type)

Russell J. Bunai Jr.

M.D.

23D. ADDRESS

University Hospital Baltimore Md.

24A. BURIAL CREMATION  
REMOVAL (Specify)

APR 26 1965

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

APR 28 1965

25B. NAME OF REGISTRAR

Robert E. Farley, M.D.

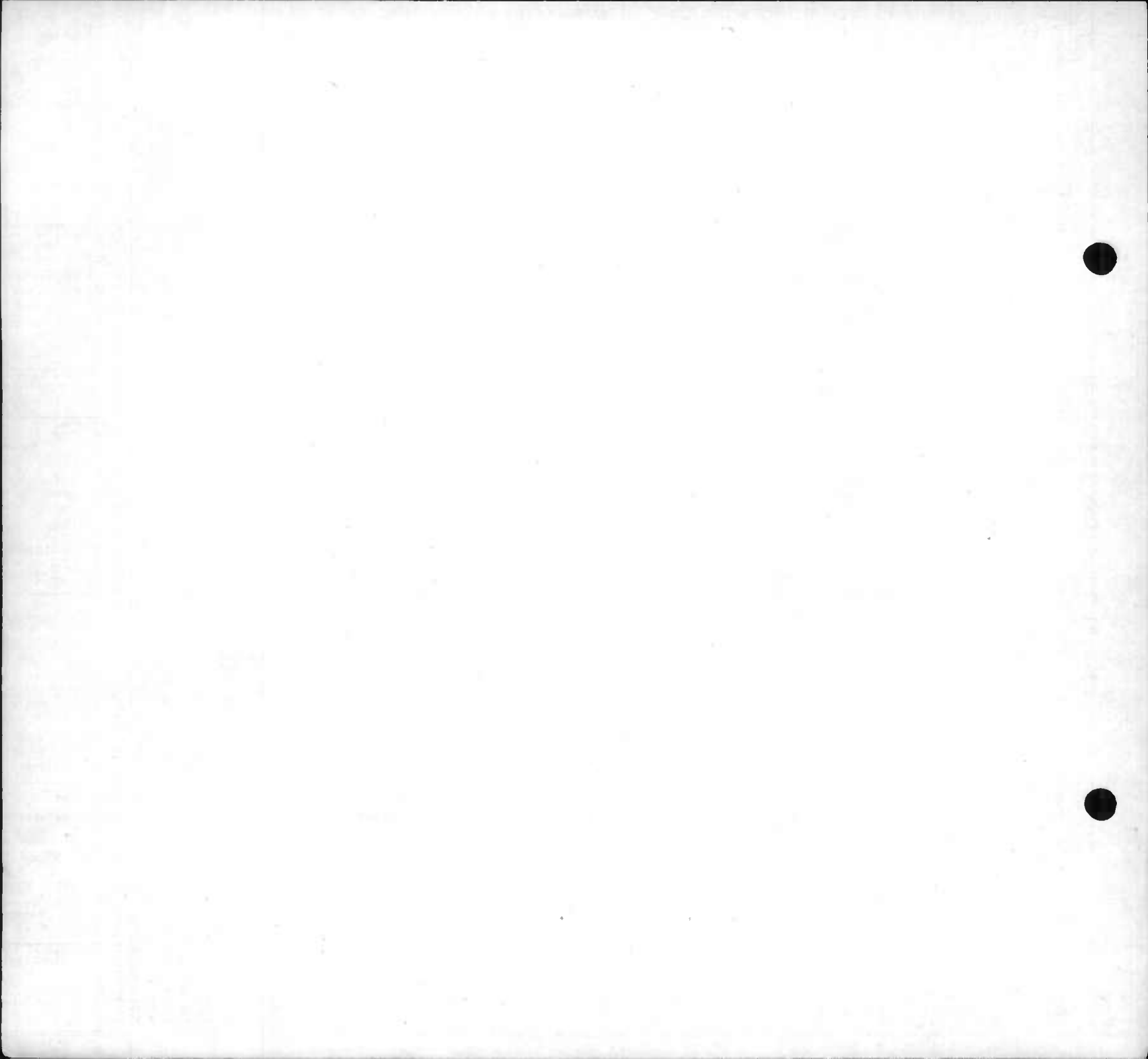
25C. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

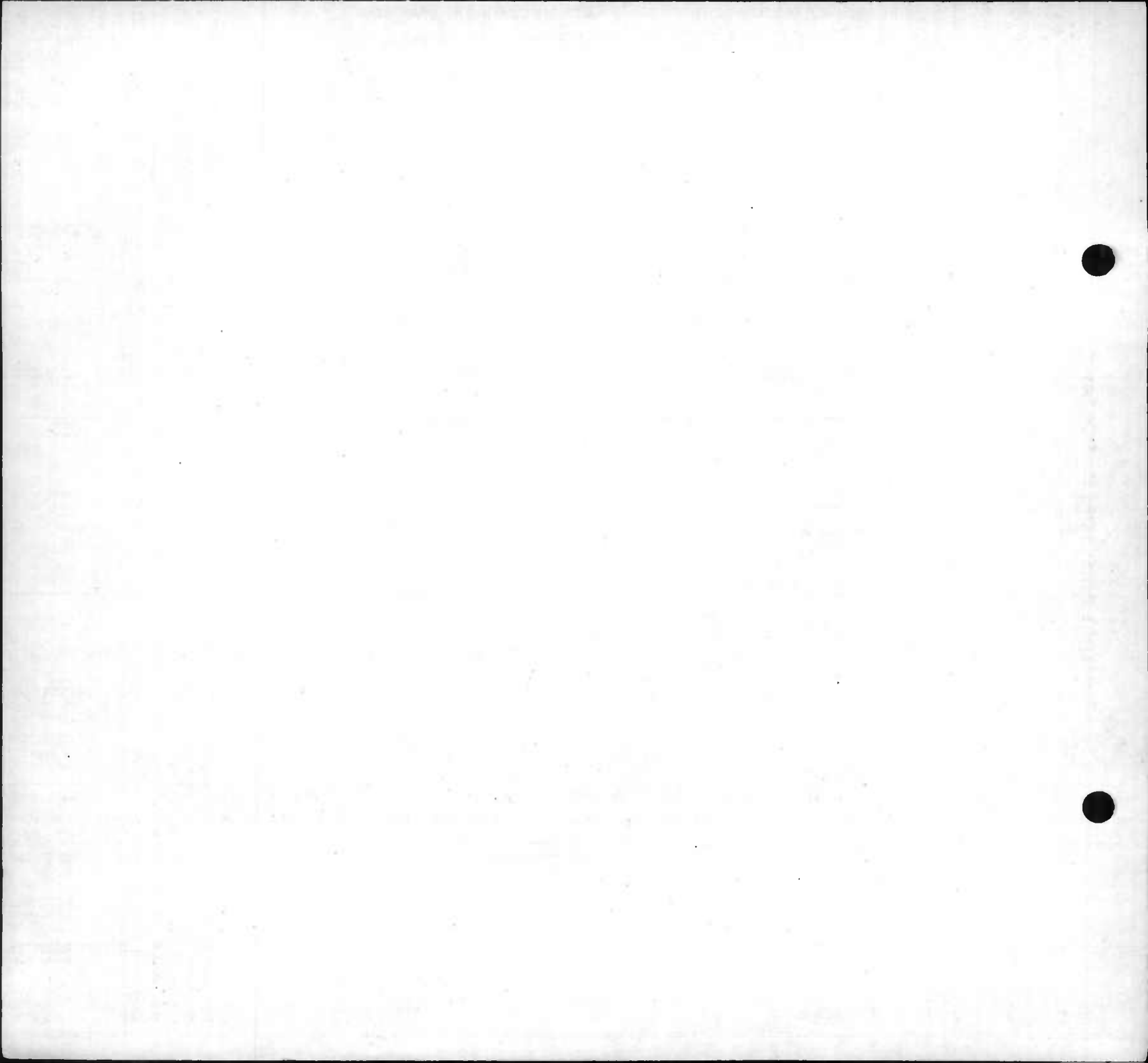
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.5em;">65 4540</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 4540</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Baby boy Snell</i>		2. DATE AND HOUR OF DEATH <i>4/19/65</i> <span style="float: right;"><i>8:30 P</i> M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>18-01 925 W. Franklin St.</i>			
5. SEX <i>male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>single</i>	8. DATE OF BIRTH <i>9/19/65</i>	9. AGE (In years last birthday) <i>N.B.</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <i>5mi</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Wayne Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Agnes Snell</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>762.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>PREmaturity</i> (A) DUE TO		CAUSE OF DEATH <i>PREmaturity</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Neonatal Atelectasis</i> DUE TO			
(C)					
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>U</i> (this hospital) attended the deceased from <i>April 19</i> 19 <i>65</i> to <i>April 19</i> 19 <i>65</i> , that <i>U</i> (we) last saw the deceased alive on <i>4/19</i> 19 <i>65</i> and that in <i>no</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>U</i> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John H. Battaglia</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>John A. B. Higgins</i>				23D. ADDRESS <i>University Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>APR 26 1965</i>		24C. NAME OF CEMETERY or CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCU</i>	

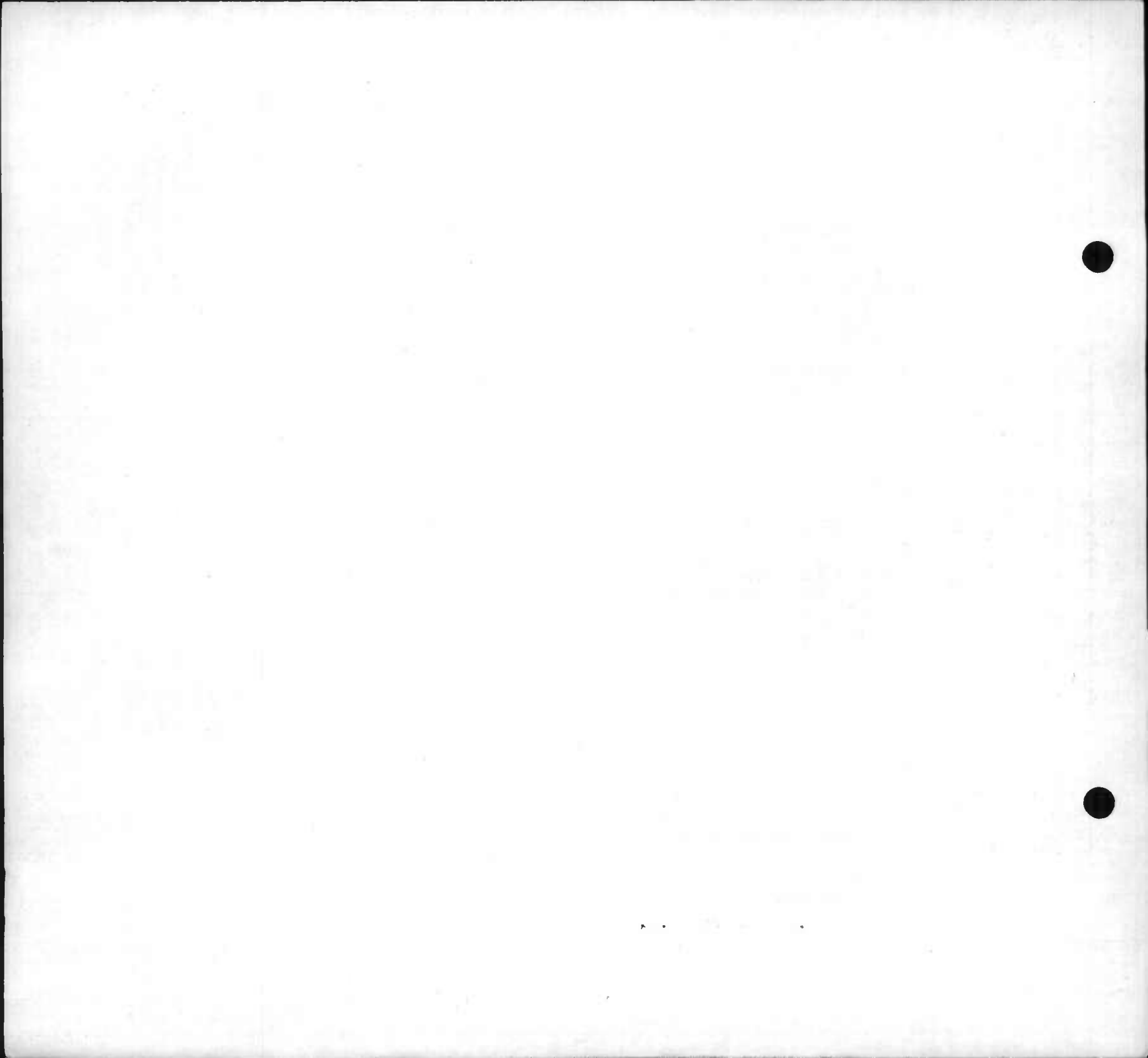




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

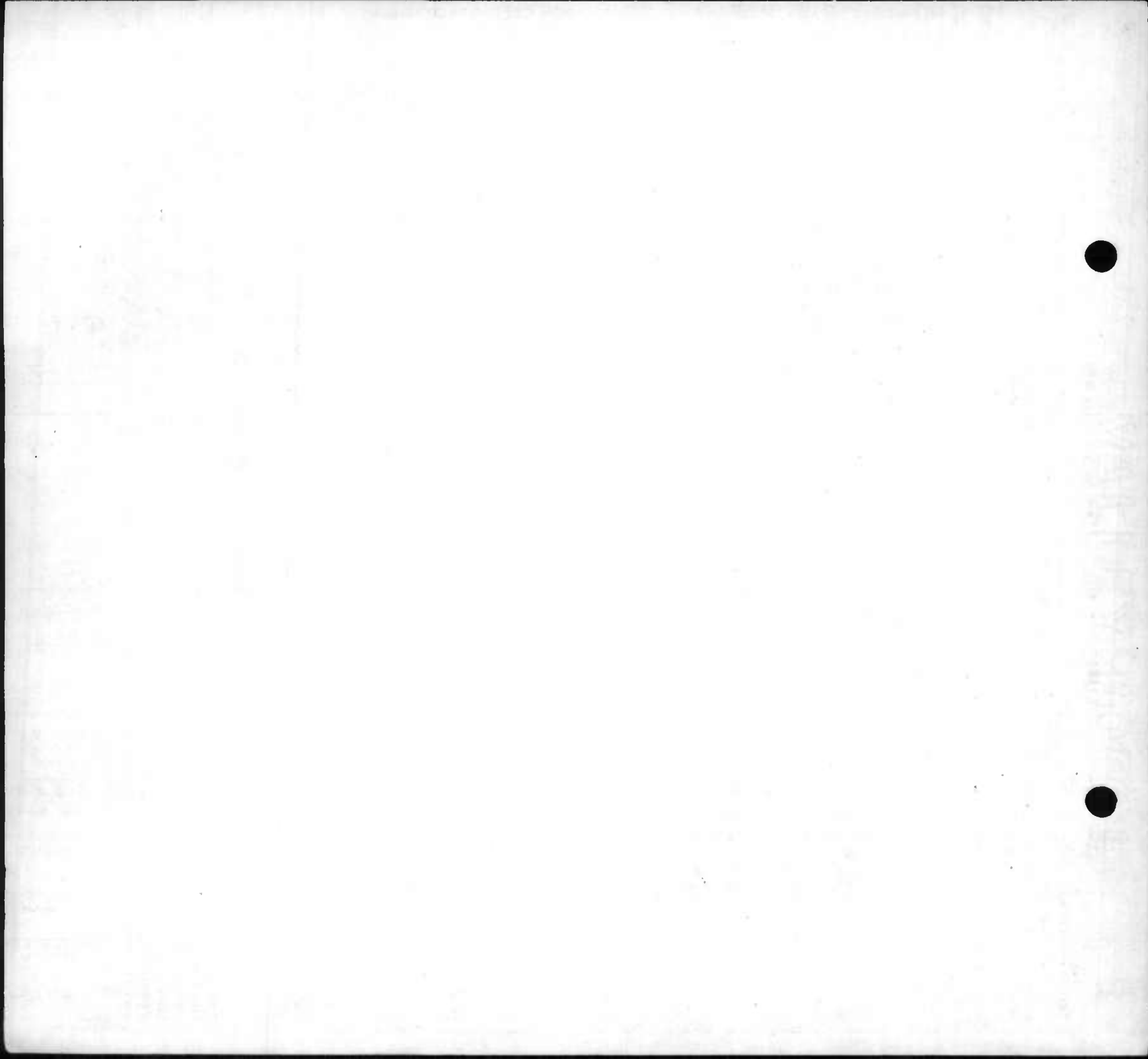
BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65-0991765 4541					REGISTERED NO. 65 4541 4		CITY HEALTH DEPARTMENT			
1. NAME OF DECEASED (Type or Print) <i>Baby Boy Winder</i>					2. DATE AND HOUR OF DEATH <i>3:10 AM 4/21/65</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>					
5. SEX <i>M</i>					6. RACE <i>Negro</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>N M</i>		8. DATE OF BIRTH <i>4/20/65</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		9. AGE (In years last birthday) <i>0</i>	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <i>Georgia Hyatt</i>					12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Asphyxia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Prematurity</i>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Multiple Ecdyemas</i>										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (i) (this hospital) attended the deceased from <i>4/20</i> 19 <i>65</i> to <i>4/21</i> 19 <i>65</i> , that (ii) (we) last saw the deceased alive on <i>4/20/1</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>H. Konzelmann</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>4/21/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>H. Konzelmann M.D.</i>					23D. ADDRESS <i>University Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>APR 26 1965</i>		24C. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i>		24D. LOCATION (City, town, or county) (State)				
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>R. E. Fairbank</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>						



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-09465 65 4542		BALTIMORE CITY HEALTH DEPARTMENT		65 4542	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>BRISCOE, BABY BOY</b>		2. DATE AND HOUR OF DEATH <b>APRIL 22 1965 8 10 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY Hosp.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1810 ETTINGES ST.</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>4/21/65</b>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 12 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>CLARENCE BRISCOE</b>		14. MOTHER'S MAIDEN NAME <b>MINERVA GARDNER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>HOSP. RECORD</b>		
18. <b>773.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>IDIOPATHIC RESPIRATORY DUE TO DISTRESS SYNDROME</b> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>PREMATURITY BW - 1290 gms</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-21-65</b> to <b>4-22-65</b> , that (I) (we) last saw the deceased alive on <b>4-22-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. Fred Baker</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-22-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. FRED BAKER</b>		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</b>			
24A. BURIAL CREMATION, DATE OF REMOVAL (Specify) <b>APR 26 1965</b>		24C. NAME of CEMETERY or CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) (State) <b>MORTUARY SERVICE - BOND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>R. E. F. J. Baker</b>		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

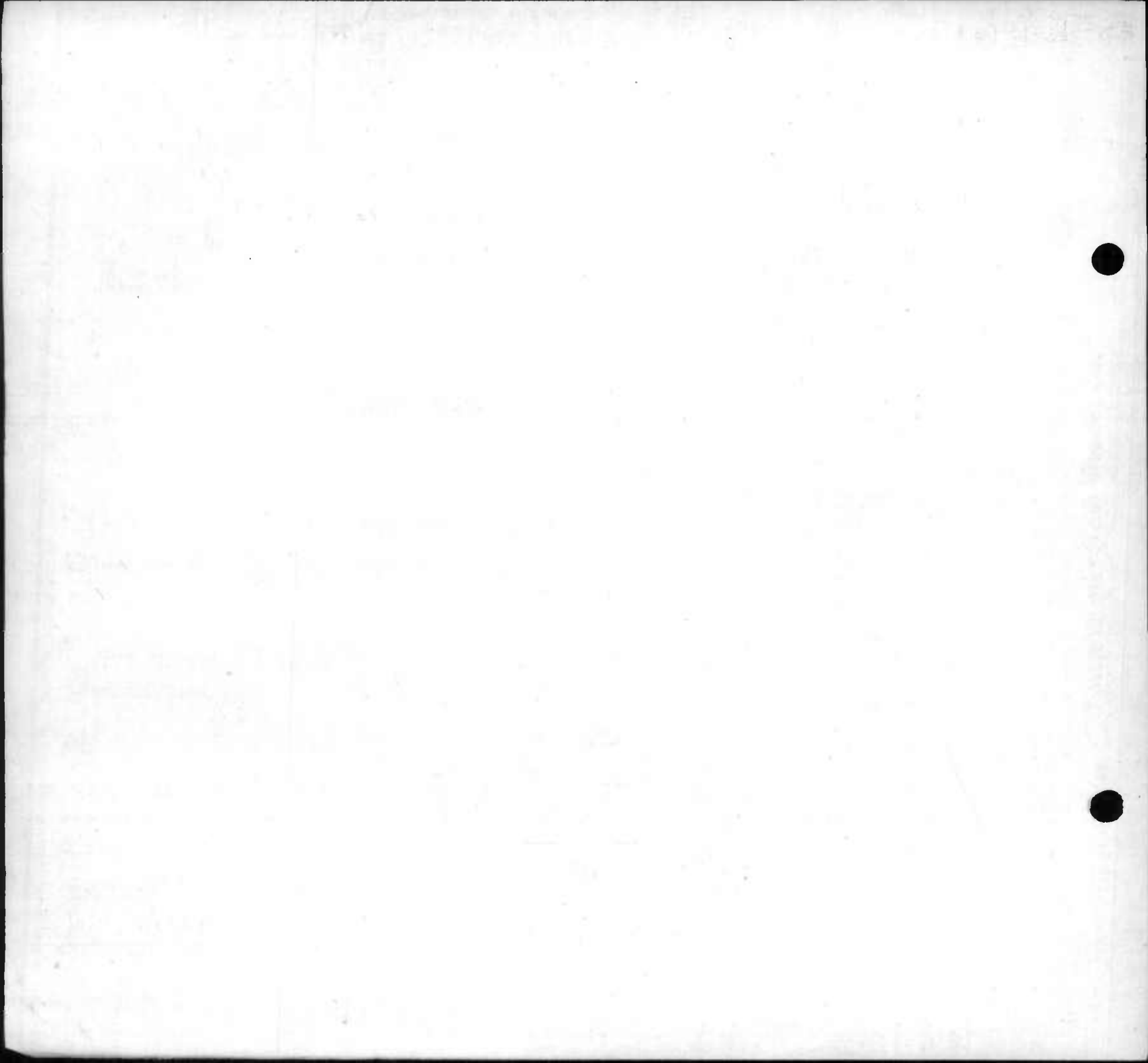
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
R-534		65 4543		65 4543	
BIRTH NO. 6508667		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY RANDOLPH</b>			2. DATE AND HOUR OF DEATH <b>April 2 1965 10<sup>15</sup> A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2002 2114 W. Shulberry St.</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>4/2/65</b>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 7 7
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>MELBA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>NEONATAL ATALECTASIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 2 1965</b> to <b>April 2 1965</b> , that (I) (we) last saw the deceased alive on <b>April 2 1965</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Kenneth Mott</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 2 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>Kenneth Mott</b>			23D. ADDRESS <b>University Hospital</b>		
24A. BURIAL CREMATION, DATE REMOVAL (Specify) <b>APR 26 1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTUARY SERVICE - BCHD</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 4544</b>	
BIRTH NO. <b>65 4544</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WILLIE SAUSAGE</b>		<b>April 20, 1965 1 55 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hosp</b>		A. STATE <b>MD</b> B. COUNTY <b>17-1</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 01</b>	
		D. STREET ADDRESS (If rural, give location) <b>832 Tessler St.</b>	
5. SEX <b>M</b>	6. RACE <b>Neg</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>12/6/1904</b>
			9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>OLD CHART</b>	
18. <b>334X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <b>Aspiration Pneumonia</b> DUE TO	
		(B) <b>Rheumatoid Spondylitis</b> DUE TO	
		(C) <b>Diffuse Encephalopathy</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>24 days</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>65</b> to <b>4/20</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/20</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Donald T. Lewers MD</b>		23B. DATE SIGNED <b>4/20/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Donald T. Lewers</b>		23D. ADDRESS <b>University Hosp, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>APR 26 1965</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>		24D. LOCATION (City, town, or county) (State) <b>UNIVERSITY MEDICAL SCHOOL</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b>	
25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHB</b>		ADDRESS	

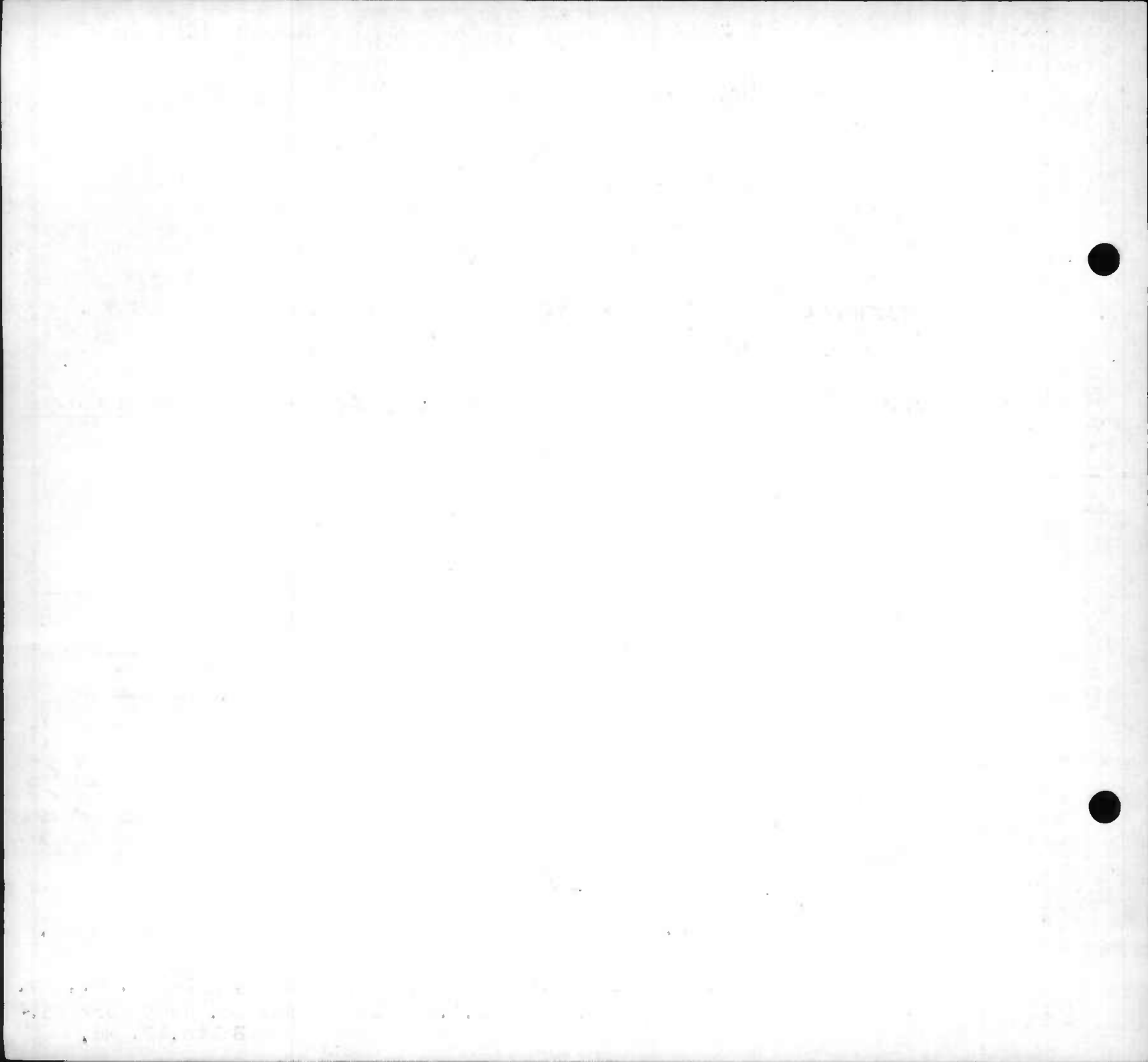




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4545</b>	
BIRTH NO. <b>65 4545</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MAY W. KAHLER</b>		2. DATE AND HOUR OF DEATH <b>April 27, 1965 11 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL BALTIMORE MD.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21218</b>			
		D. STREET ADDRESS (If rural, give location) <b>3627 OLD YORK RD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>6/18/90</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MARTIN SEABOLT LEROY WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>HESTER A. DEAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MARTIN W. SEABOLT, 3703 GREEN WAY</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b>		CAUSE OF DEATH (A) <b>Myocardial infarction</b> DUE TO (B) <b>Postoperative splenic laceration</b> DUE TO (C) <b>Rapidly progressive atherosclerosis?</b> <b>Jaundice??</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4/27</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4/26/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>JAUNDICE (PAINLESS)</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 26</b> 19 <b>65</b> to <b>April 27</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 27</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph J. Mowad</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/27/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Joseph J. Mowad</b>		23D. ADDRESS M.D. <b>University Hospital, Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge</b>	
24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4546		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 4546	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Lena M. Walter		2. DATE AND HOUR OF DEATH 4-25-65 1:50 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Wisconsin			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Montebello S. Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Salisbury 72-12			
		D. STREET ADDRESS (If rural, give location) 301 N. Division St			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 5-20-94	9. AGE (In years last birthday) 69	10. Under 1 Yr. Months Days Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY H. W		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Thomas Muir Walter		14. MOTHER'S MAIDEN NAME Schwartz SARAH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Montebello S. Hospital	
18. 1419 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cancer of the tongue.		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1 March 1965 to 4-25-1965, that (I) (we) last saw the deceased alive on 4-25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Orlando G. Ramos		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-25-65	
23C. PHYSICIAN'S NAME (Type) Orlando G. RAMOS		23D. ADDRESS Montebello S. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/28/1965		24C. NAME OF CEMETERY or CREMATORY St. Mary's Cemetery	
24D. LOCATION FURNKIN, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR E. S. S. S.		25C. FUNERAL DIRECTOR L. L. Johnson Co, Salisbury, MD.	

1924 3-25-4

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FUNERAL DIRECTOR: IMPORTANT

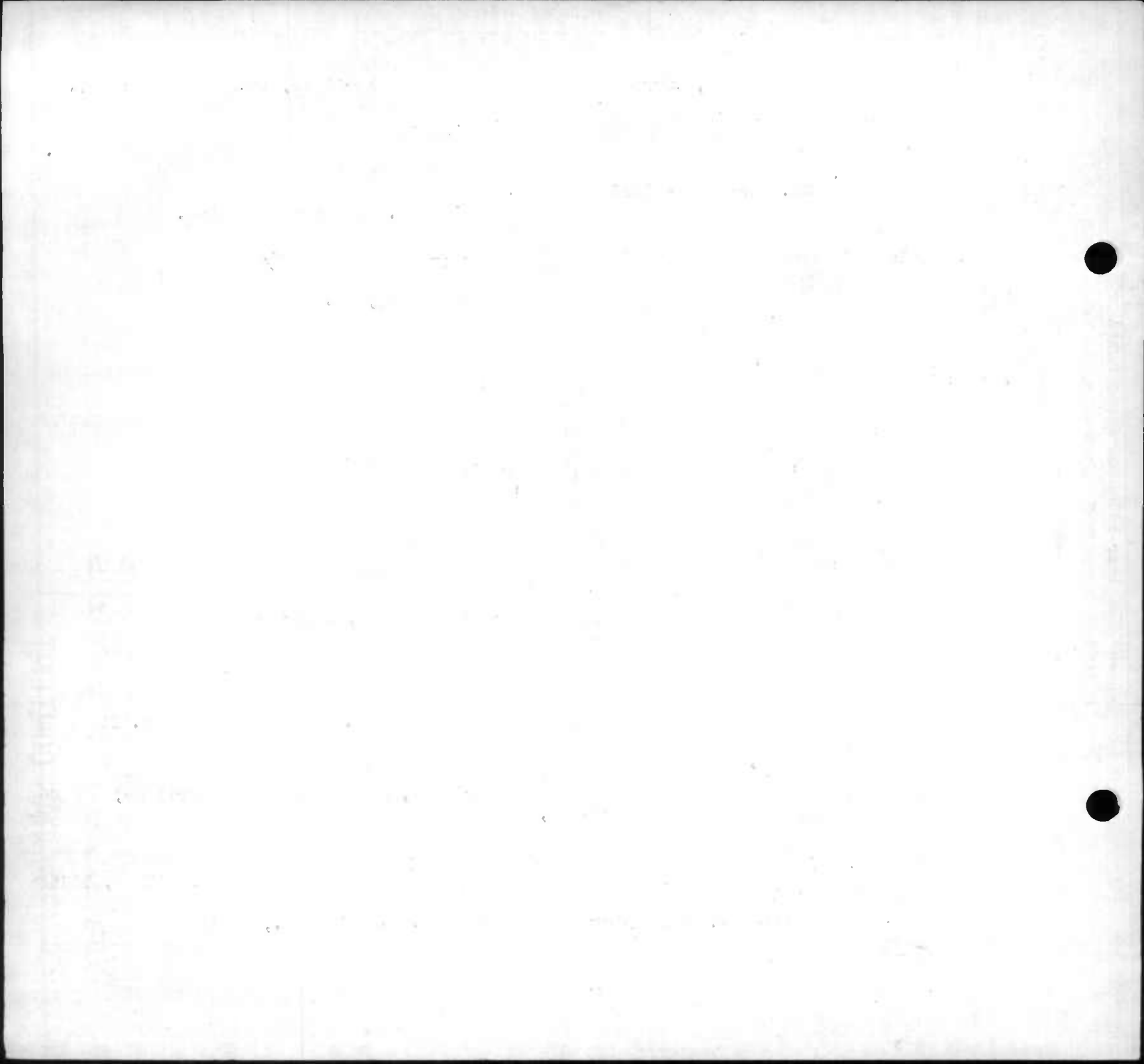
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance at the deceased prior to death); and (6) No physician was in regular attendance at the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4547	
CERTIFICATE OF DEATH				Registered No. 65 4547	
BIRTH NO. 65 4547					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ERLINE, FRANK J.		April 25, 1965 11:55 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		A. STATE Md. B. COUNTY 8-01			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BLOB SUPERINTENDENT		10B. KIND OF BUSINESS OR INDUSTRY OFFICE BUILDING		8. DATE OF BIRTH 11-15-1915 79	
13. FATHER'S NAME JOHN ERLINE		14. MOTHER'S MAIDEN NAME MARY ZIMMERMAN		9. AGE (In years last birthday) 79	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-6248		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		17. INFORMANT SON ADDRESS MR. EDWARD ERLINE 7604 BAGLEY AVE PARKVILLE			
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Brain stem hemorrhage DUE TO (B) Hypertensive cardiovascular DUE TO (C) disease			
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/16 19 65 to 4/25 19 65, that (I) (we) last saw the deceased alive on 4/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Alonso				23B. DATE SIGNED 4/25/65	
23C. PHYSICIAN'S NAME (Type) Bernardino A. Alonso				23D. ADDRESS 1400 N. Caroline Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-1965		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	
24D. LOCATION BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1965			
25B. NAME OF REGISTRAR Robert E. Finken		25C. FUNERAL DIRECTOR J. Walter Conklin			
25D. ADDRESS 5444 Belair Rd.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4548				CITY HEALTH DEPARTMENT		Registered No. 65 4548	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Beste, Harry</b>				2. DATE AND HOUR OF DEATH <b>April 25, 1965 7:50 A.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore #13</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #13</b> D. STREET ADDRESS (If rural, give location) <b>1941 N. Patterson Park Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-29-1880</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Package Dept.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Delivery Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Herman Beste</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Sawyer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>243-28-0185</b>		17. INFORMANT <b>Ruth W. Beste - Same</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Fractures of right humerus and left pelvis</b>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Fractures of right humerus and left pelvis</b>							
21A. DATE OF OPERATION <b>2</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No) <b>Yes</b>		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1941 N. Patterson Park Ave. 21213</b>			
21D. TIME OF INJURY (APPROX.) <b>April 15, 1965</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell down steps</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1965</b> to <b>April 25, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 25, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William B. VandeGrift</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 25, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>William B. VandeGrift</b>				23D. ADDRESS <b>1400 N. Caroline St., 21213</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>John C. Miller Inc.</b>		25C. FUNERAL DIRECTOR <b>John C. Miller Inc.</b>		ADDRESS <b>6415 Belair Rd</b>	

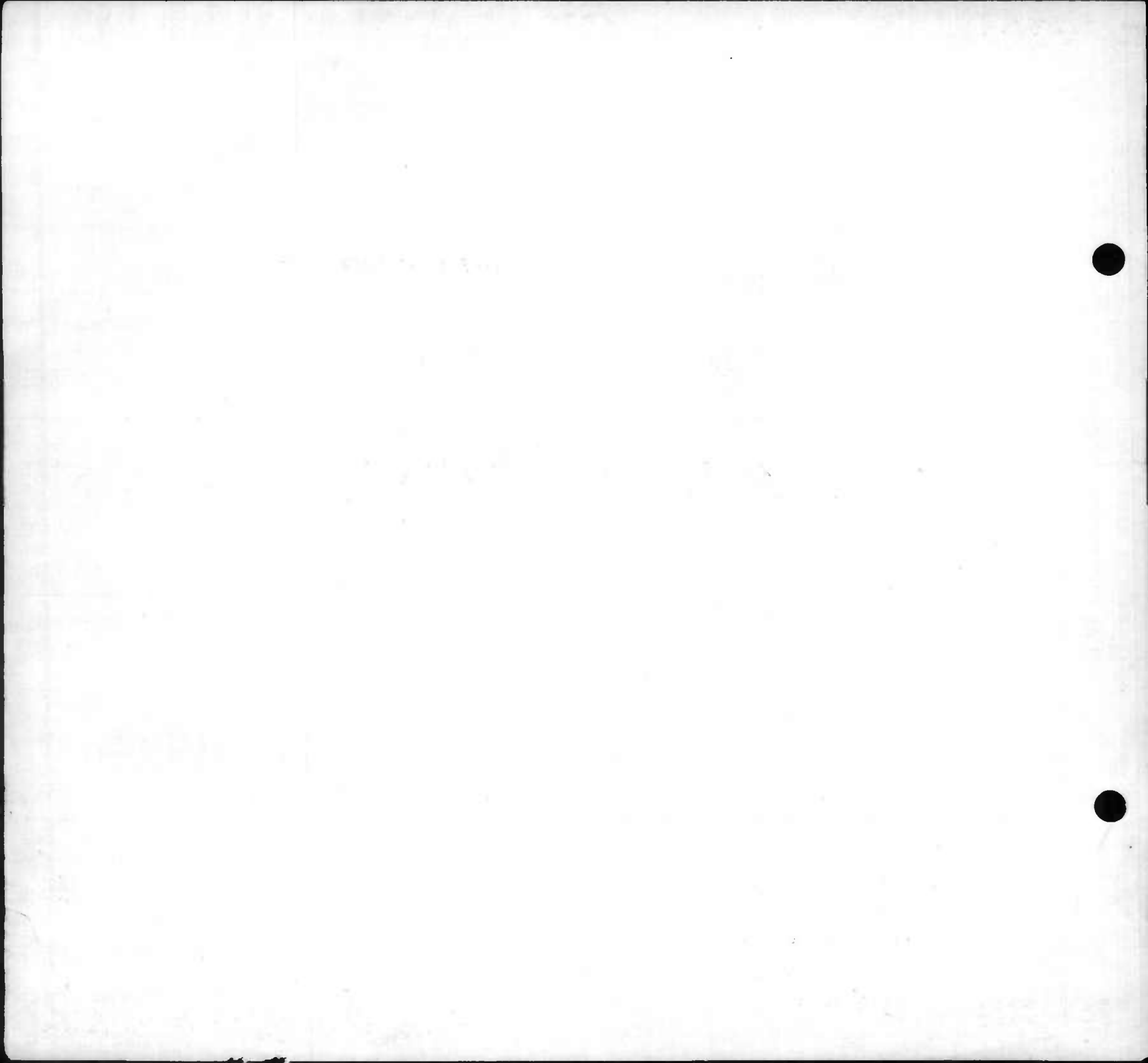




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

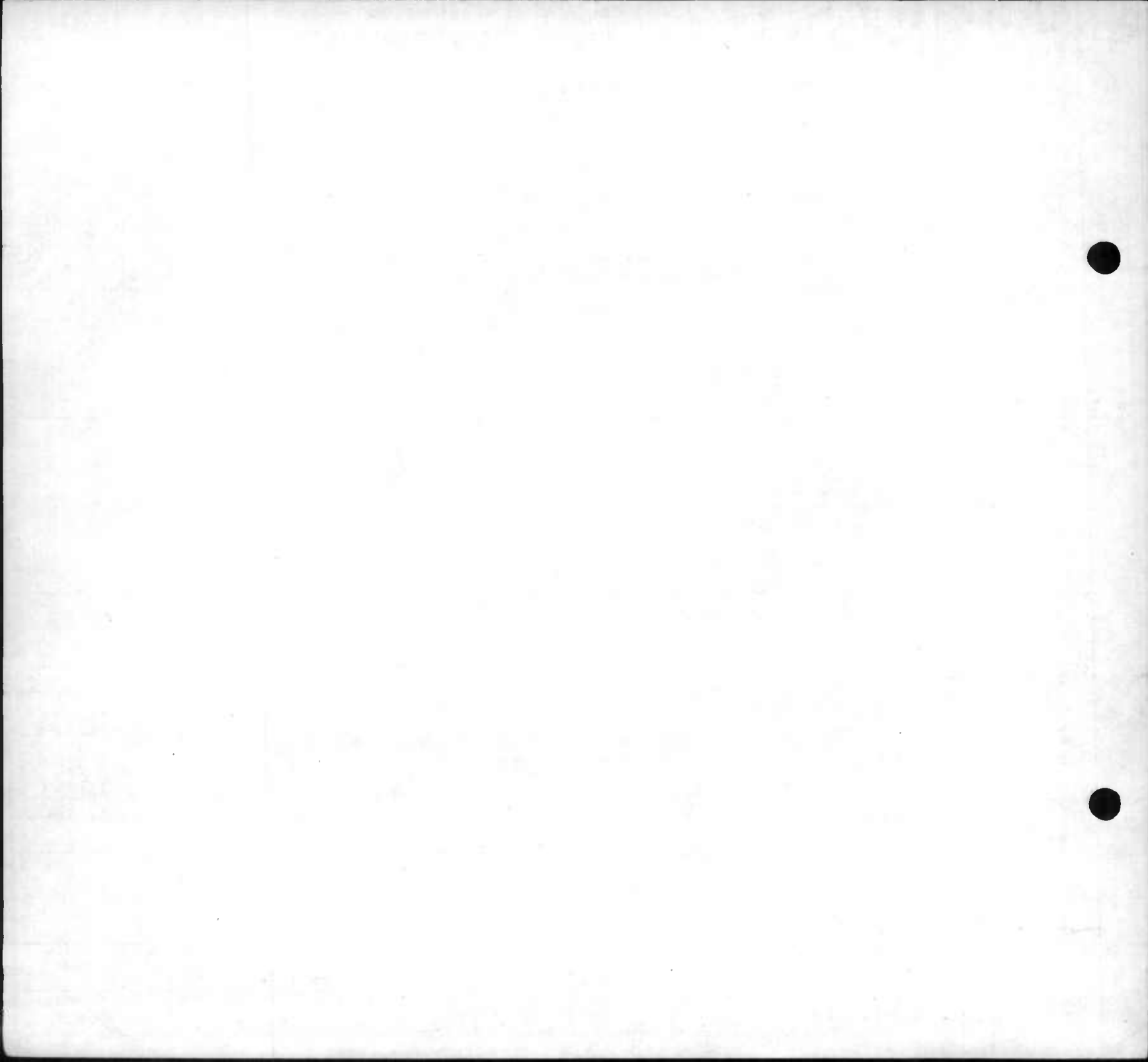
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4549	
BIRTH NO. 65 4549		M.E. CASE NO. 65 4549				1. NAME OF DECEASED (Type or Print) Rufus Smith		2. DATE AND HOUR OF DEATH 4/27/65 8:20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 Johns Hopkins Hospital						A. STATE Maryland B. COUNTY 10-02					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore						D. STREET ADDRESS (If rural, give location) 909 Somerset St. # 2					
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH MAY 16, 1920		9. AGE (in years) 45		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Turkey, Inc.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Gilbert Smith						14. MOTHER'S MAIDEN NAME Ada Thompson					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Sally Champion		ADDRESS 905 Somerset St. - Baltimore, Md.			
18. 587.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH (A) Acute pulm. edema		INTERVAL BETWEEN ONSET AND DEATH 5 min.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Transfusion ? / or myocardial failure		10-15 min			
						(C) Chronic small bowel fistula, peritonitis; pancreatitis		2 wks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Alcoholism											
19A. DATE OF OPERATION 3/17/65, 4/3/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED chronic pancreatitis; intest. obstr.		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from March 3, 1965 to April 27, 1965, that (I) (we) last saw the deceased alive on April 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. B. Peacock						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 27, 1965			
23C. PHYSICIAN'S NAME (Type) J. B. Peacock				23D. ADDRESS John Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 4/28/65		24C. NAME OF CEMETERY or CREMATORY SAN HILL		24D. LOCATION (City, town, or county) CLINTON, N.C.		(State)			
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Joseph B. Rock Jr.		ADDRESS 1304 N. Central A.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 4550	
BIRTH NO. 65-10486 65 4550		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Baby Girl Fahres		2. DATE AND HOUR OF DEATH 4/24/65 10 <sup>30</sup> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPT.				A. STATE B. COUNTY 27-48			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location) 6172 PARKWAY DR			
5. SEX F	6. RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married	8. DATE OF BIRTH 4/24/65	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min. 30m	11. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL H. FAHRES				14. MOTHER'S MAIDEN NAME MARY L. WIEDEFELD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		HOSTP. RECORDS -	
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) Im maturity		INTERVAL BETWEEN ONSET AND DEATH 20min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/24/65 10 <sup>30</sup> PM to 4/24 10 <sup>30</sup> PM that (I) (we) last saw the deceased alive on 4/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Willard E. Standiford				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/25/65	
23C. PHYSICIAN'S NAME (Type) Willard E. Standiford				23D. ADDRESS Mercy Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/27/65		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) BALTO - (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR WIEDEFELD & SON		ADDRESS 501 E. 22ND ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4551		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4551	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print)			4/23/65 7:30 A.M.		
MARY C. DRECHSLER					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
In not in hospital or institution, give street address or location			A. STATE B. COUNTY		
2618 St. Paul Street			Maryland 12-06		
5. SEX			6. DATE OF BIRTH		
Female			1881 1882 83		
7. RACE			9. AGE (In years last birthday)		
White			83		
10. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			11. BIRTHPLACE (State or foreign country)		
Widowed			Harford Co. Md.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			12. CITIZEN OF WHAT COUNTRY?		
at home					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Jeremiha Crowley			Mary Abbott		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			-----		
17. INFORMANT			ADDRESS		
Mrs. Helen Hollander-(daughter)					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Chronic myocarditis		
19. ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 19 64 to April 23, 19 65, that (I) (we) lost saw the deceased alive on 4/23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. Willis Guyton				4/24/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. Willis Guyton				M.D. 3961 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/26/65		Holy Redeemer Gem. City	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 28 1965		Robert E. Taylor, M.D.		WIEDEFELD & SON-501 E. 22nd St.	

V.S. 153

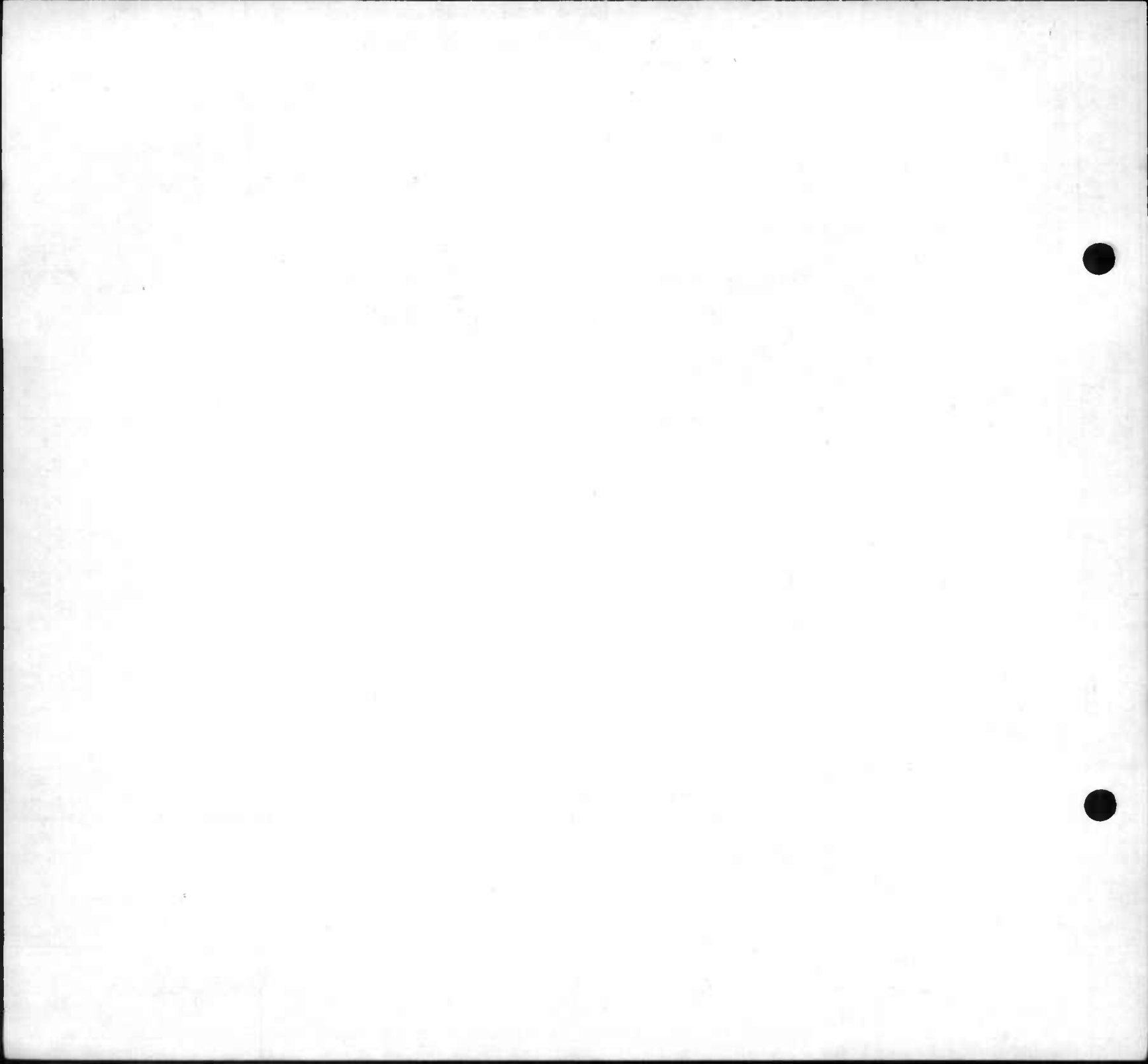
5-11-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4552	
CERTIFICATE OF DEATH					
BIRTH NO. 65 4552					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <i>ELLEN (NEELIE) CONWAY</i>		2. DATE AND HOUR OF DEATH <i>4-26-65 640 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>37 mercy</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Balt</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>8519 Look Raven Blvd. 5300</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>	8. DATE OF BIRTH <i>1/19/05</i>	9. AGE (In years last birthday) <i>60</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>STATE OF MD.</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO MD.</i>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>JAMES MULLIGAN</i>			14. MOTHER'S MAIDEN NAME <i>CATHERINE O'CONNELL</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>HOSPT. RECORDS.</i>	
18. <i>150X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <i>Acute Gastric Hemorrhage</i> (A) DUE TO <i>Carcinomatosis</i> (B) <i>Esophagous</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/26 1965</i> to <i>4/26 1965</i> , that (I) (we) last saw the deceased alive on <i>4/26 1965</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David M. Michalski</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>David Michalski</i>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/29/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>BALTO NAT'L CEMETERY</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Blair E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Frederick (Son)</i>	

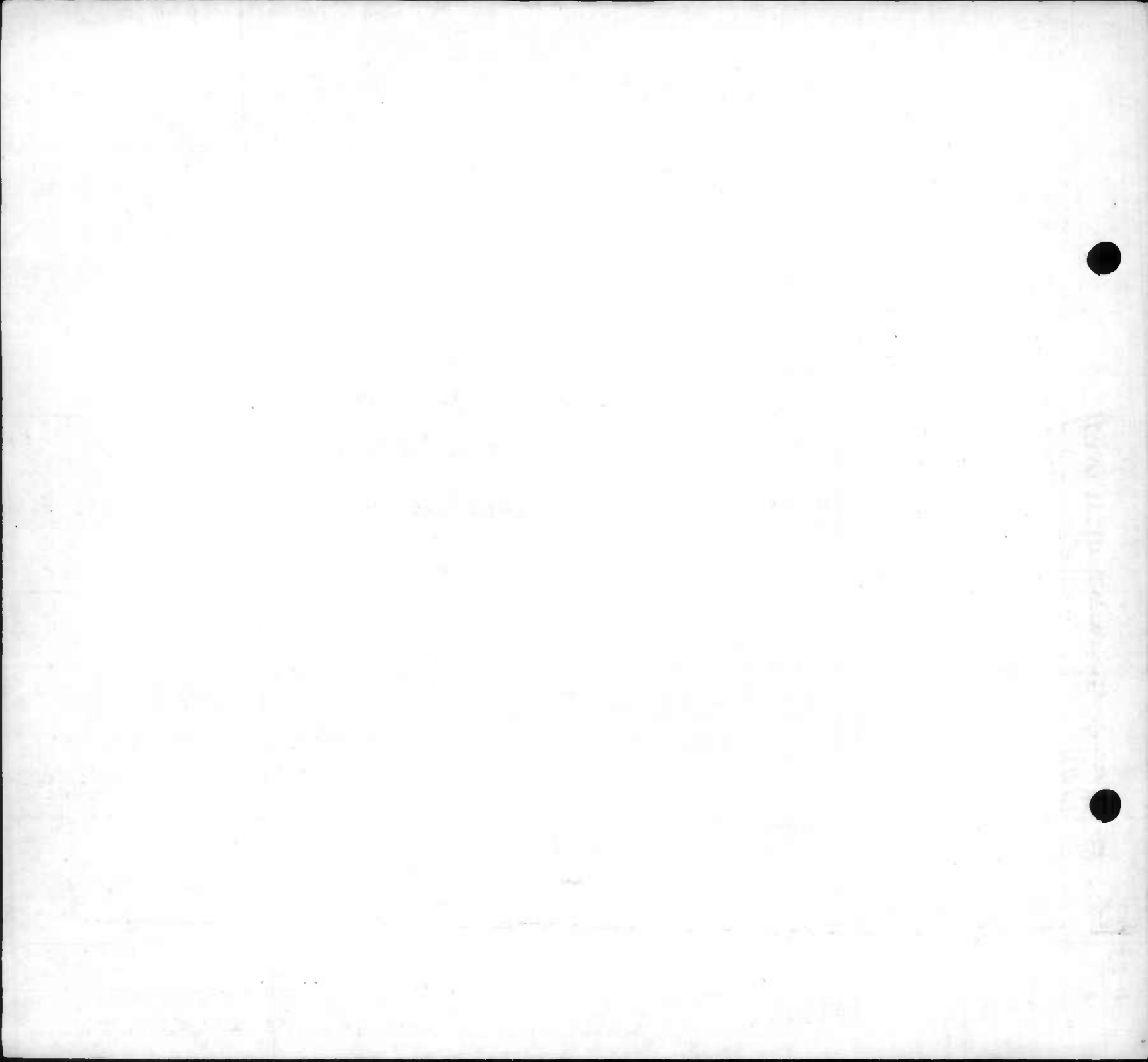




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

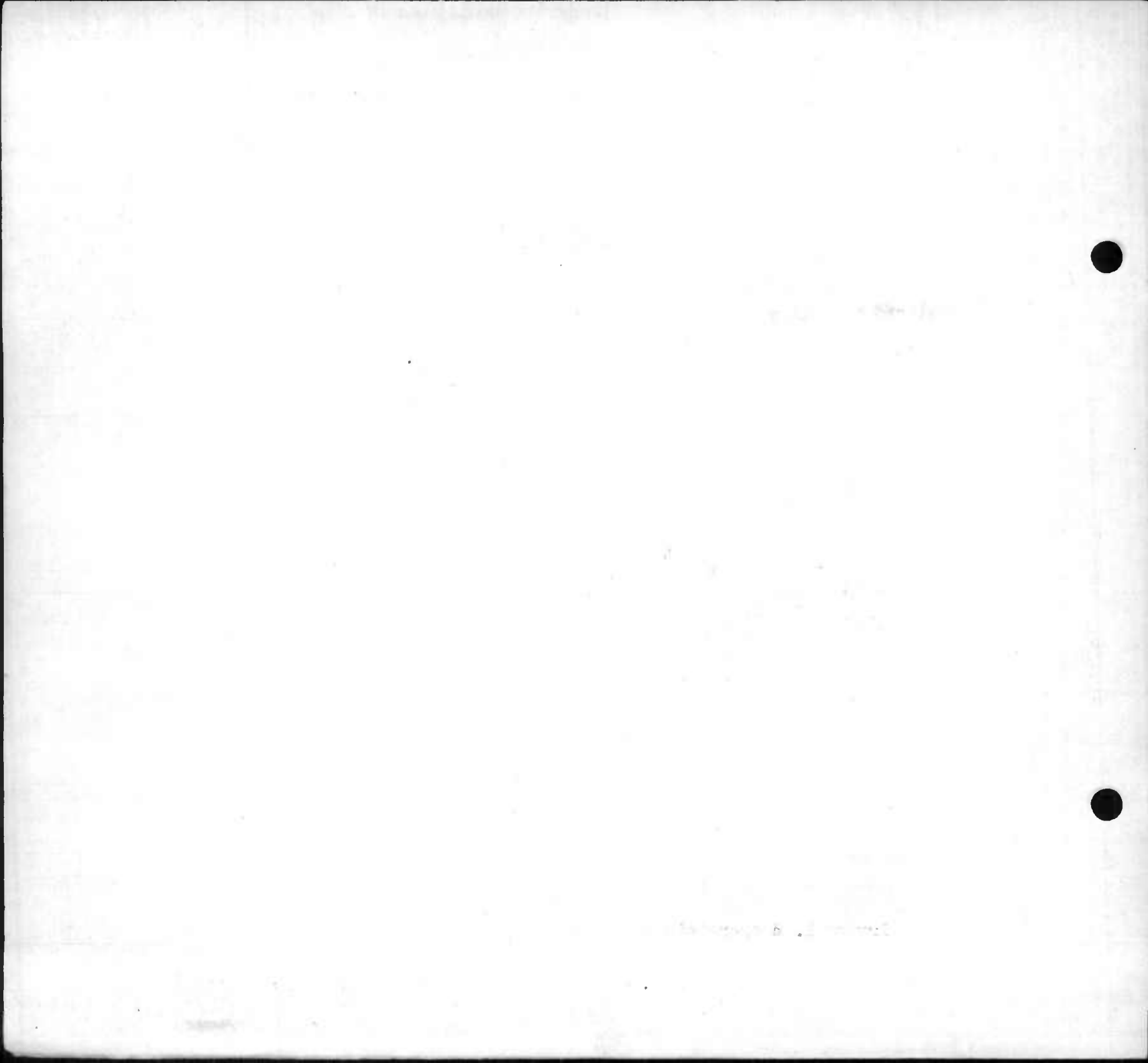
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 4553		CERTIFICATE OF DEATH		65 4553	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Herman Trent		April 24, 1965 6:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Maryland General Hospital		Maryland 12-07			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2115 N. Howard St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months: Days: Hours: Min.
M	Negro	Single	Oct. 20, 1894	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				Limestone, Tenn.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WWI		231-05-5502		Allie Fountain 1028 N. Eden Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO CEREBRAL HEMORRHAGE, MASSIVE, (R) CEREBROVASCULAR DISEASE (B) DUE TO HYPERTENSIVE CEREBROVASCULAR DISEASE (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 24 1965 to April 24 1965, that (I) (we) last saw the deceased alive on April 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
L. G. Tilley				April 24, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
L. G. Tilley		Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		28 Apr 65		Balto National Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 28 1965		R. E. Taylor		A. Holstead 918 Druid Hill Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

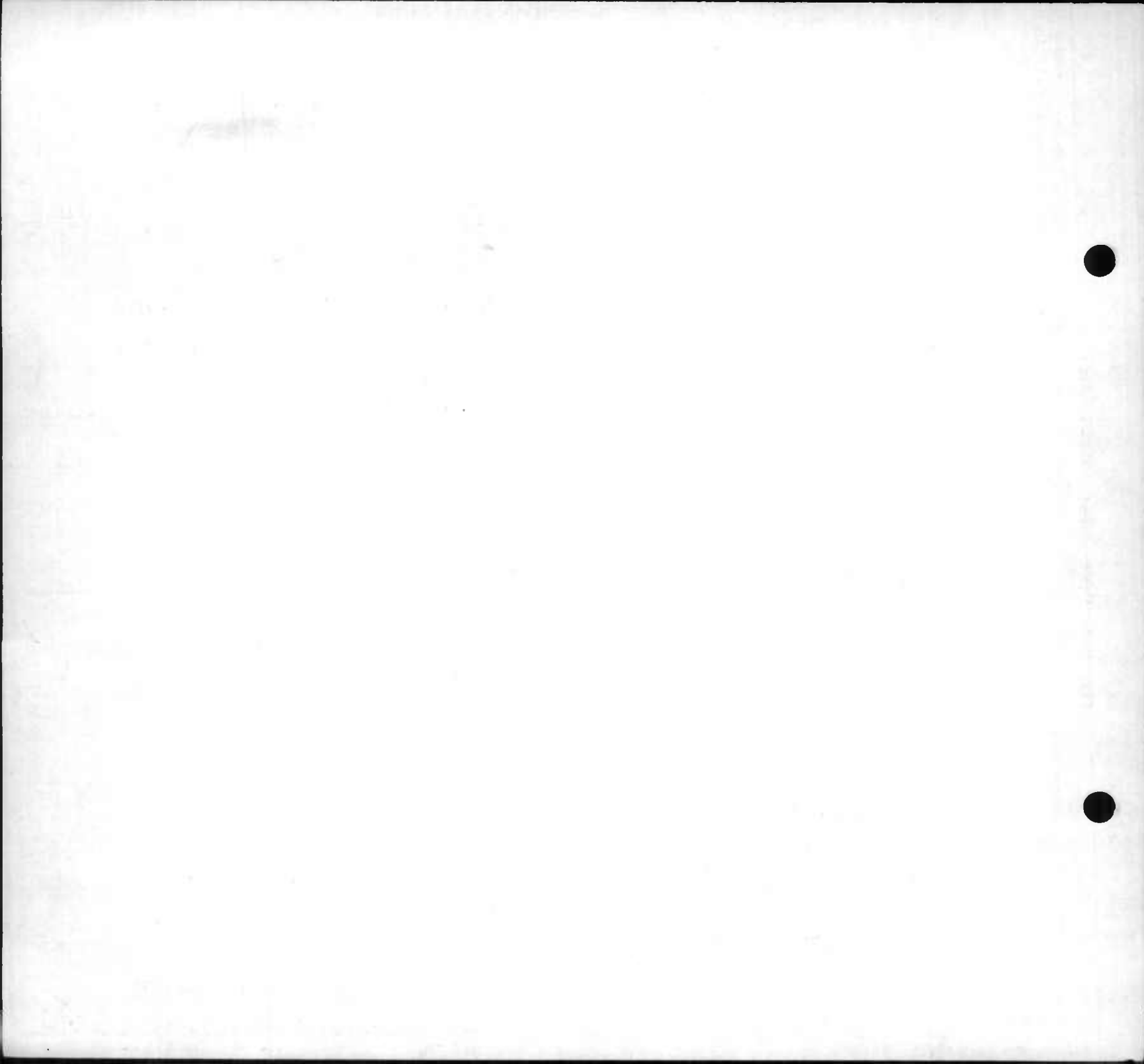
BALTIMORE CITY HEALTH DEPARTMENT																				
BIRTH NO. 65 4554					CERTIFICATE OF DEATH					Registered No. 65 4554										
1. NAME OF DECEASED (Type or Print) AIDA SHAFFER					2. DATE AND HOUR OF DEATH 4-27-65 12:15 P.M.															
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. 21-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5802 THE ALAMEDA 21212															
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 10-12-76		9. AGE (In years last birthday) 88		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Secretary					10B. KIND OF BUSINESS OR INDUSTRY Insurance					11. BIRTHPLACE (State or foreign country) MD.					12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME JAMES SHAFFER					14. MOTHER'S MAIDEN NAME Sallie B. SKINNER					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT Miss BESSIE SHAFFER		ADDRESS SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CEREBRAL THROMBOSIS (B) ARTERIOSCLEROSIS (C) _____ INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS										19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROSIS OBLITERANS 4 DAYS										
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)										
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?										
22. I certify that (X) (this hospital) attended the deceased from 12-21 1964 to 4-27 1965, that (X) (we) lost saw the deceased alive on 4-27 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.																				
23A. SIGNATURE Irving L. Cooperstein M.D.										23B. DATE SIGNED 4-27-65										
23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein										23D. ADDRESS MONTEBELLO HOSP., BALTO., MD.										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/30/1965					24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery					24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965					25B. NAME OF REGISTRAR Robert E. Farber, M.D.					25C. FUNERAL DIRECTOR Wm. J. Fisher & Sons					ADDRESS Balto., Md. 21217 + Pa. Ave.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

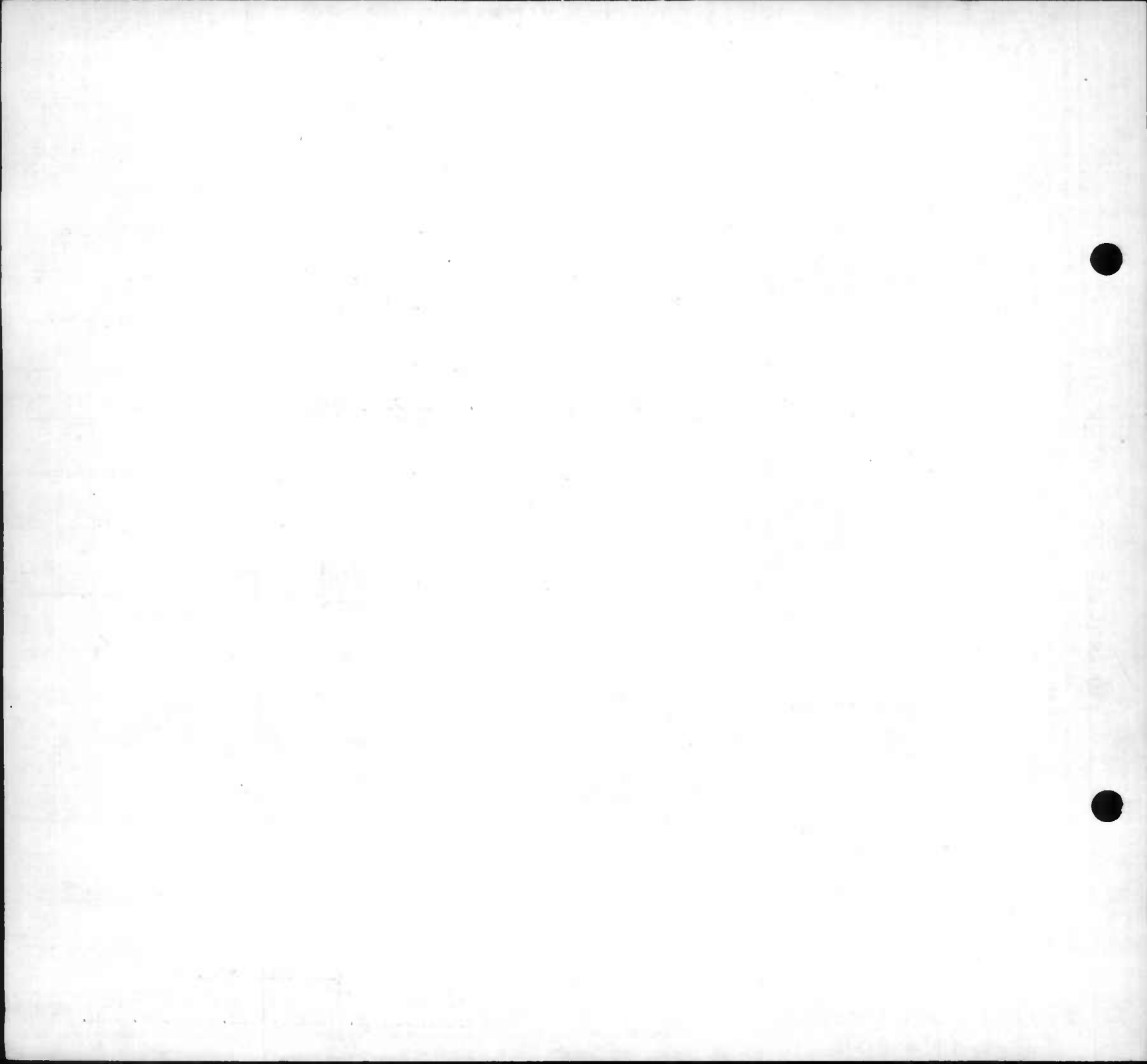
BALTIMORE CITY HEALTH DEPARTMENT				65 4555	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. 65 4555		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) Mary W. Sloan			2. DATE AND HOUR OF DEATH 4-28-65 6:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 6300 Eastern Pkwy 21214		
5. SEX F	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widow	8. DATE OF BIRTH Sept 15, 1896	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wheeling W. VA.	
13. FATHER'S NAME John E. Wright			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John Sloan Baltimore, Maryland 21214	
18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) OUE TO (C)		
19A. DATE OF OPERATION O			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-28-65 to 4-28-65 that (I) (we) last saw the deceased alive on 4-28-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodney L. Brimhall M.D.				23B. DATE SIGNED 4-28-65	
23C. PHYSICIAN'S NAME (Type) RODNEY L. BRIMHALL			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREATION, REMOVAL (Specify) Burial		24B. DATE 4/30/1965		24C. NAME OF CEMETERY or CREMATORY Rose Hill Cemetery	
24D. LOCATION (City, town, or county) Cumberland, Maryland		24E. LOCATION (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965		25B. NAME OF REGISTRAR R. E. FALKNER		25C. FUNERAL DIRECTOR Wm. J. Fickner & Son	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4556				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4556	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LEPPERT, IVY, M.</u>				2. DATE AND HOUR OF DEATH <u>APRIL 27 1965</u> <u>7.15 P.M.</u>			
3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>8-D</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>2009 BELAIR ROAD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10/27/85</u>	9. AGE (In years last birthday) <u>79</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>MARTIN SCHIMP</u>				14. MOTHER'S MAIDEN NAME <u>Emily</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212205492B</u>		17. INFORMANT <u>Mr. Peter Leppert</u>	
				ADDRESS <u>Same</u>			
18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cerebrovascular Accident</u> DUE TO (B) <u>Cerebral Arteriosclerosis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 25 1965</u> to <u>APRIL 27 1965</u> , that (I) (we) last saw the deceased alive on <u>APRIL 27 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert W. Garis</u> <u>Chi Tsung Su M.D.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/27/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT W. GARIS</u>				23D. ADDRESS <u>12 E. EAGER ST., BALTIMORE-2, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/1/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>				25B. NAME OF REGISTRAR <u>Robert E. Ruck</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc., Balto., Md.</u>	

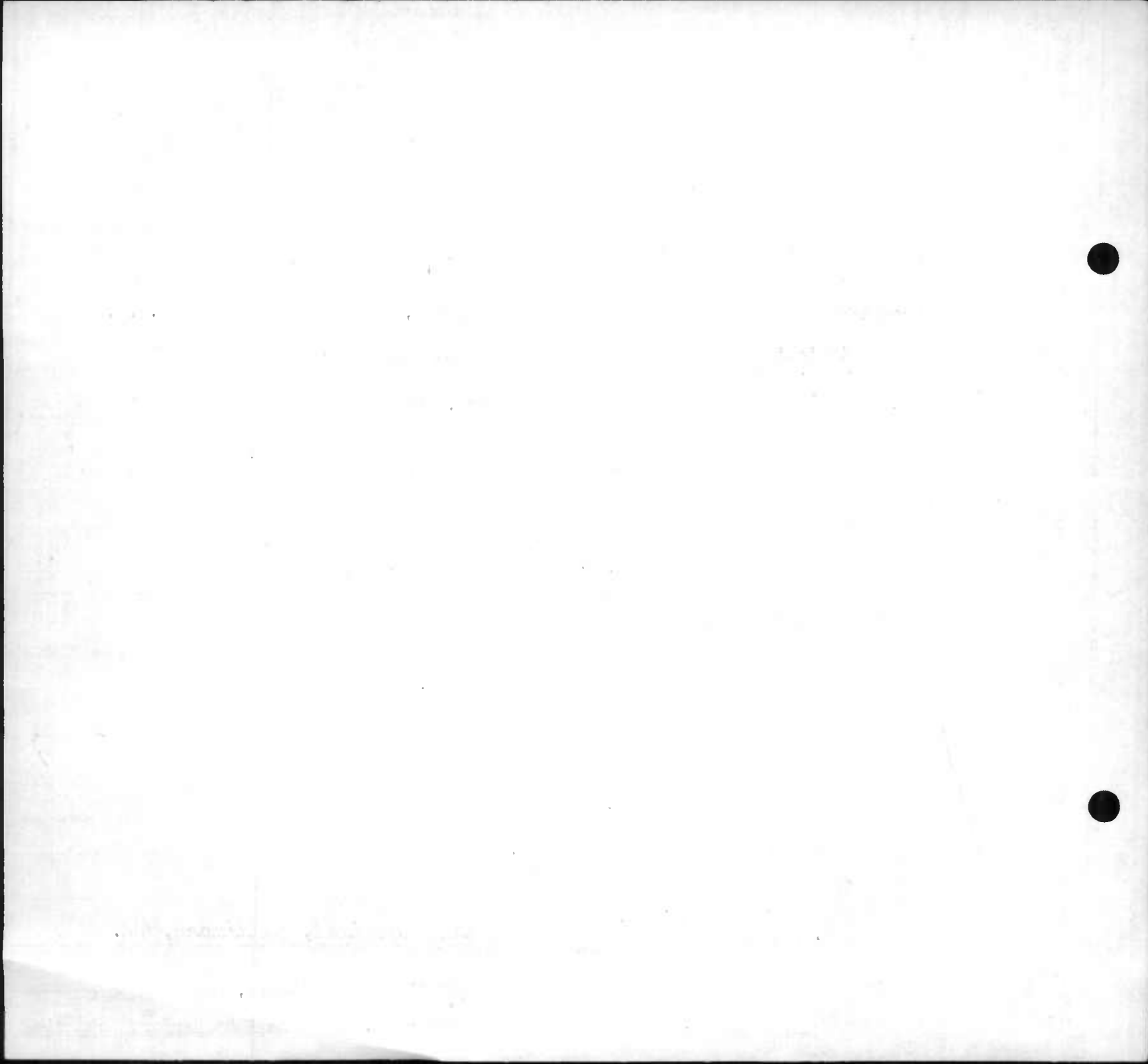




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

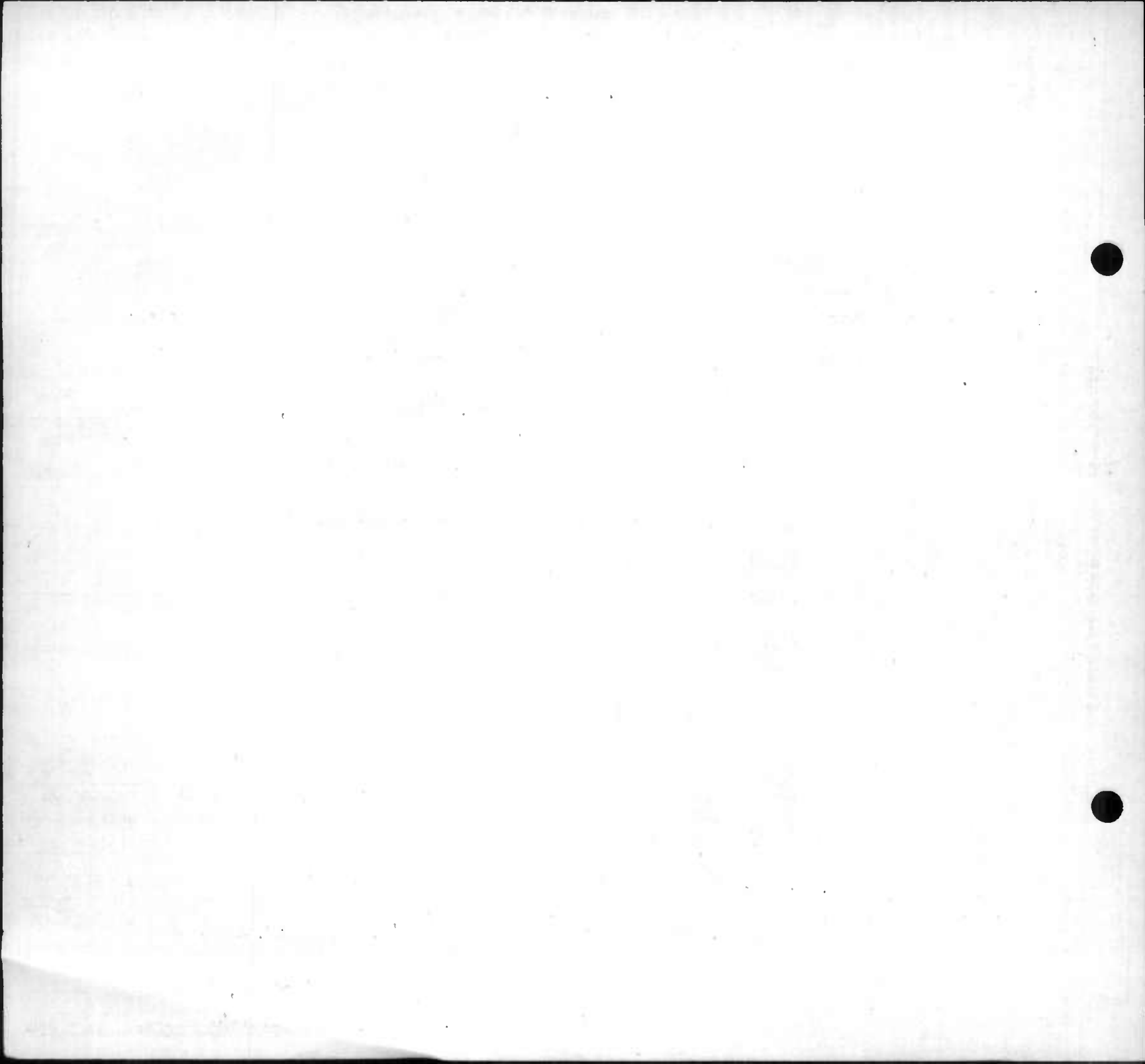
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4557</u>	
BIRTH NO. <u>65 4557</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Anna D. Foster</u>				4/29/65 2:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mercy Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>9-06</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
				D. STREET ADDRESS (If rural, give location) <u>2827 The Alameda</u>	
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>Mar 17, 1893</u>	9. AGE (In years last birthday) <u>71</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Camden, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Bielicki</u>			14. MOTHER'S MAIDEN NAME <u>Mary Gemeninski</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Charlotte Rajotte 2827 The Alameda</u>
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Anterosclerotic C-V Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Myocardial Infarction</u> <u>Pne. Pulmonary Infection</u>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 24th</u> 19 <u>65</u> to <u>APRIL 27</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>APRIL 27</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stuart R. Remley</u>				23B. DATE SIGNED <u>4/27/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stuart R. Remley</u>				23D. ADDRESS M.D. <u>Mercy Hospital, Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc 5305 Harford Road #14</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

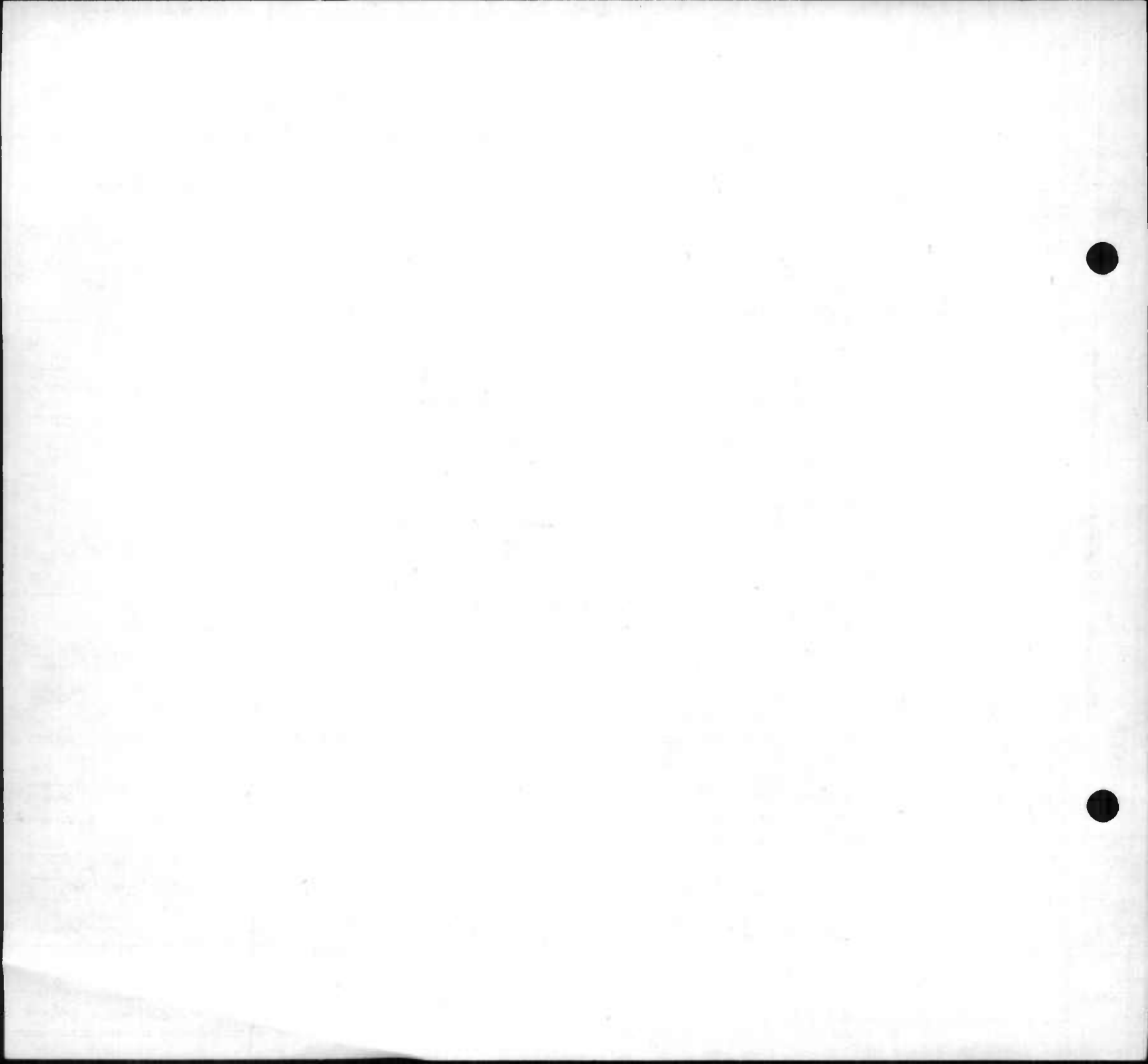
BALTIMORE CITY HEALTH DEPARTMENT									
65 4558 CERTIFICATE OF DEATH					65 4558 Registered No.				
1. NAME OF DECEASED (Type or Print) <b>DUFFY, WILLIAM M. Sr.</b>					2. DATE AND HOUR OF DEATH <b>April 28, 1965 4:50 A.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Joseph Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>8-05</b>				
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>					8. DATE OF BIRTH <b>8/13/92</b> 9. AGE (In years last birthday) <b>72</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>					11. BIRTHPLACE (State or foreign country) <b>Delaware</b>				
10B. KIND OF BUSINESS OR INDUSTRY					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Luke Duffy</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Maloney</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Mrs. Elizabeth Duffy,</b>					ADDRESS <b>same</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hepatic Failure</b> DUE TO (A) <b>Cirrhosis - nutritional</b> (B) DUE TO (C) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/8</b> 19 <b>65</b> to <b>4/28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Benjamin V. del Carmen</i> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Benjamin V. del Carmen</b> M.D.					23D. ADDRESS <b>1400 N. Caroline Street</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>4/30/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Wilmington, Delaware</b>			24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>			25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>			25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc 5305 Harford Road #14</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

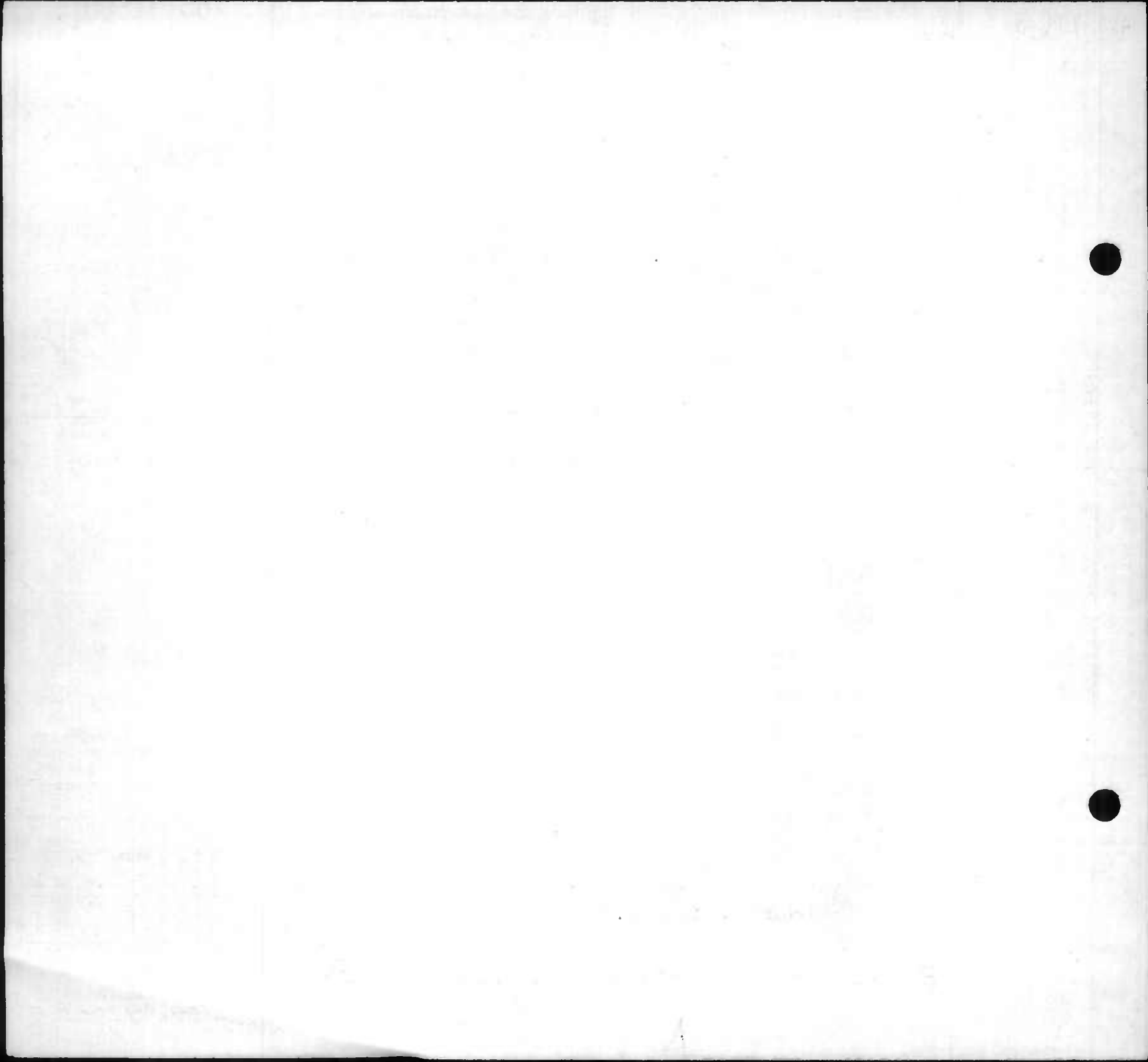
BIRTH NO. 65 4559		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4559	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) HARRY NARLINS		2. DATE AND HOUR OF DEATH 4/27/65 5:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 15-05	
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL		(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) 2312 Ocala Ave.	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3/16/1904	9. AGE (In years last birthday) 62	10. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former cab driver		10B. KIND OF BUSINESS OR INDUSTRY cab driver		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME -		14. MOTHER'S MAIDEN NAME -	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Joseph Narlins	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 351XY1260X (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Cerebral Atherosclerosis DUE TO (C) Diabetes Mellitus, peripheral vasculopathy, insufficiency, Arteriosclerotic Heart Disease, Gout		INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 4/13 1965 to 4/27 1965, that (X) (we) last saw the deceased alive on 4/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melvin J. Kordon		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/27/65	
23C. PHYSICIAN'S NAME (Type) MELVIN JOEL KORDON		M.D. 23D. ADDRESS SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/29/1965		24C. NAME OF CEMETERY or CREMATORY SOUTHERN AVE. BALTO. MD	
24D. LOCATION (City, town, or county) (State) BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. APR 29 1965		25B. NAME OF REGISTRAR Sylvan S. Lewis & Son, Inc.	
25C. ADDRESS 3319 Olympia Ave.		25D. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		25E. ADDRESS 3319 Olympia Ave.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No.	
BIRTH NO. 65 4560							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)		SAMUEL HALPERT				2. DATE AND HOUR OF DEATH 26 APRIL 65 2:20 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSP BALTIMORE MD.		A. STATE MARYLAND				B. COUNTY 5300	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21234					
		D. STREET ADDRESS (If rural, give location) 3423 GREENWAY RD.					
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED		8. DATE OF BIRTH 15 APRIL 1900	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK HALPERT				14. MOTHER'S MAIDEN NAME REBECCA HARRINGTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-03-4732		17. INFORMANT SELF			
18. 204.01		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) TERMINAL SEPSIS DUE TO				3 DAYS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO				5 YEARS	
		(C)					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8 APRIL 19 65 to 26 APRIL 19 65, that (I) (we) last saw the deceased alive on 26 APRIL 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard D. Biggs Jr.				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 26 April 65	
23C. PHYSICIAN'S NAME (Type) RICHARD D. BIGGS JR.				23D. ADDRESS UNIVERSITY HOSPITAL BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/29/65		24C. NAME OF CEMETERY OR CREMATORY HEBREW FRIENDSHIP		24D. LOCATION (City, town, or county) (State) BALTO. MD	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1965		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC. 3317 OLYMPIA AVE			

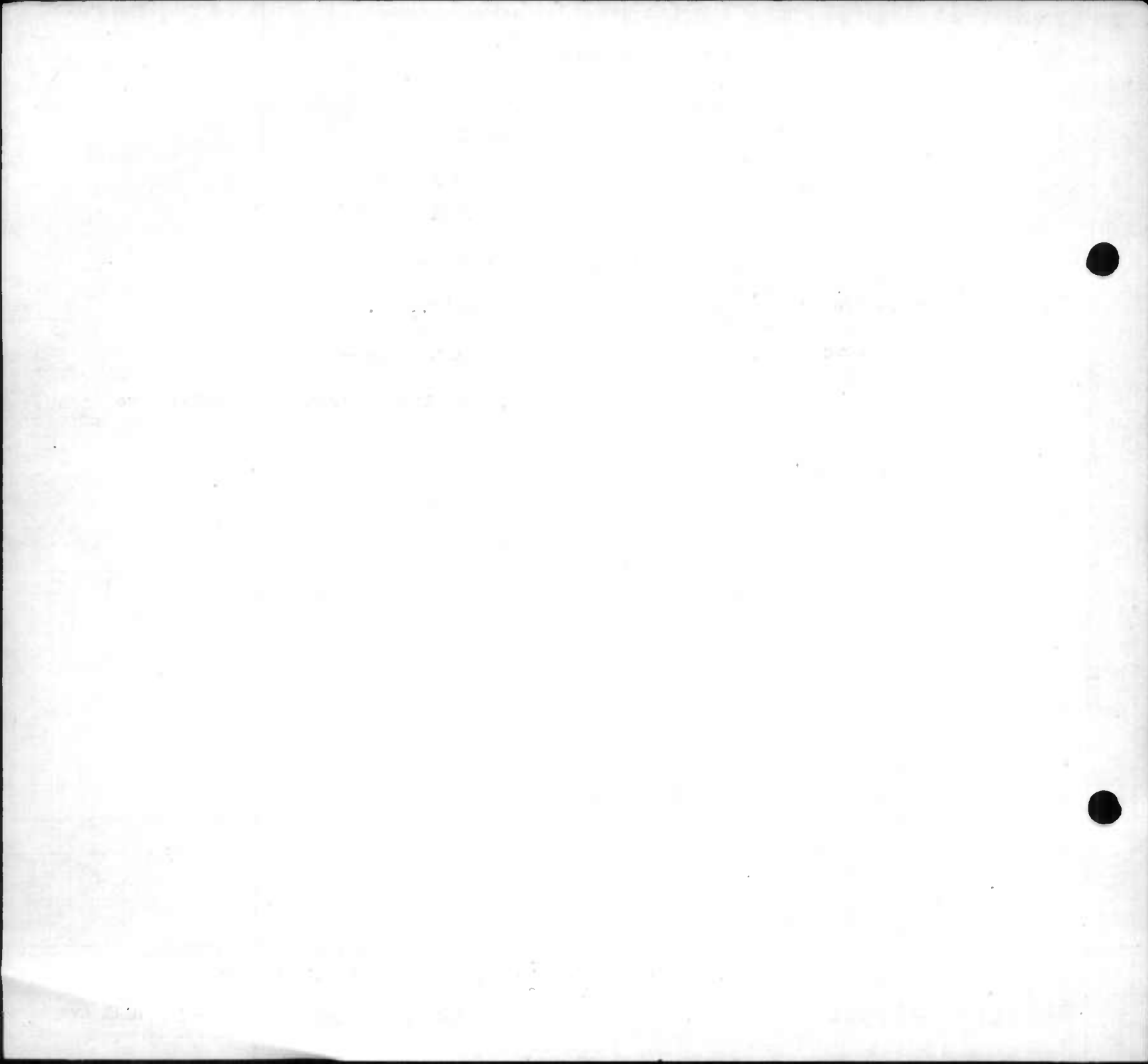




FUNERAL DIRECTOR: IMPORTANT

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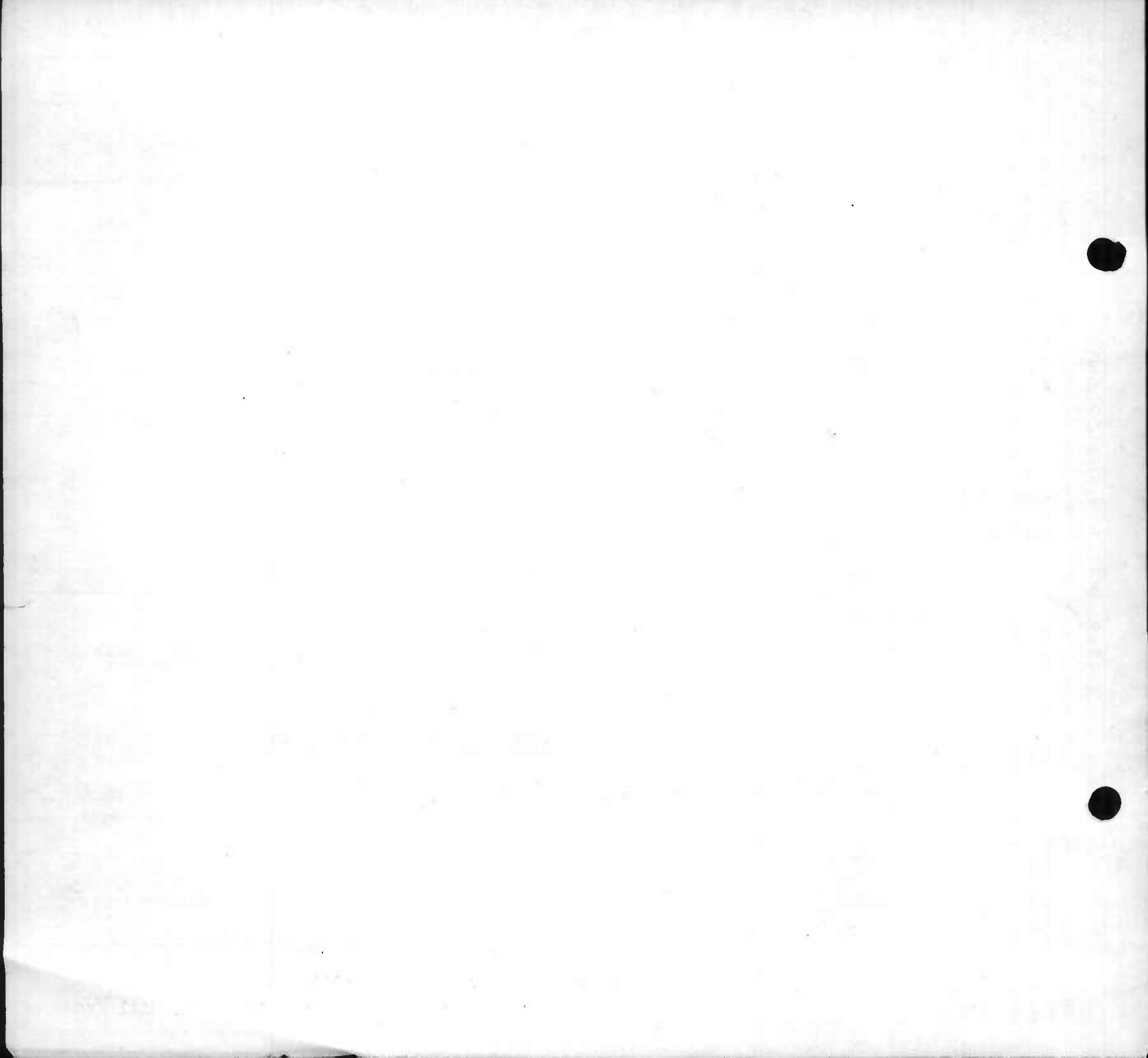
BALTIMORE CITY HEALTH DEPT.				Certificate of Death		Registered No. <b>65 4561</b>	
BIRTH NO. <b>65 4561</b>		M.E. CASE NO. <b>65 4561</b>		1. NAME OF DECEASED (Type or Print) <b>Gene Williams</b>		2. DATE AND HOUR OF DEATH <b>4-26-65</b> <b>9:20</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1011 W Lexington St</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 8, 1890</b>		9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Annie Gross</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs Viola Johnson 2829 Garrison Ave</b>		
18. <b>4-20-65</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Marked Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b> <b>Arteriosclerotic Cardiovascular Disease</b>				CAUSE OF DEATH (A) <b>Marked Pulmonary Edema</b> DUE TO (B) <b>Myocardial Infarction</b> DUE TO (C) <b>Arteriosclerotic Cardiovascular Disease</b>			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 24</b> 19 <b>65</b> to <b>April 26</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 26</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Adolphus Halstead</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/27/65</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b>		ADDRESS <b>918 Druid Hill Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

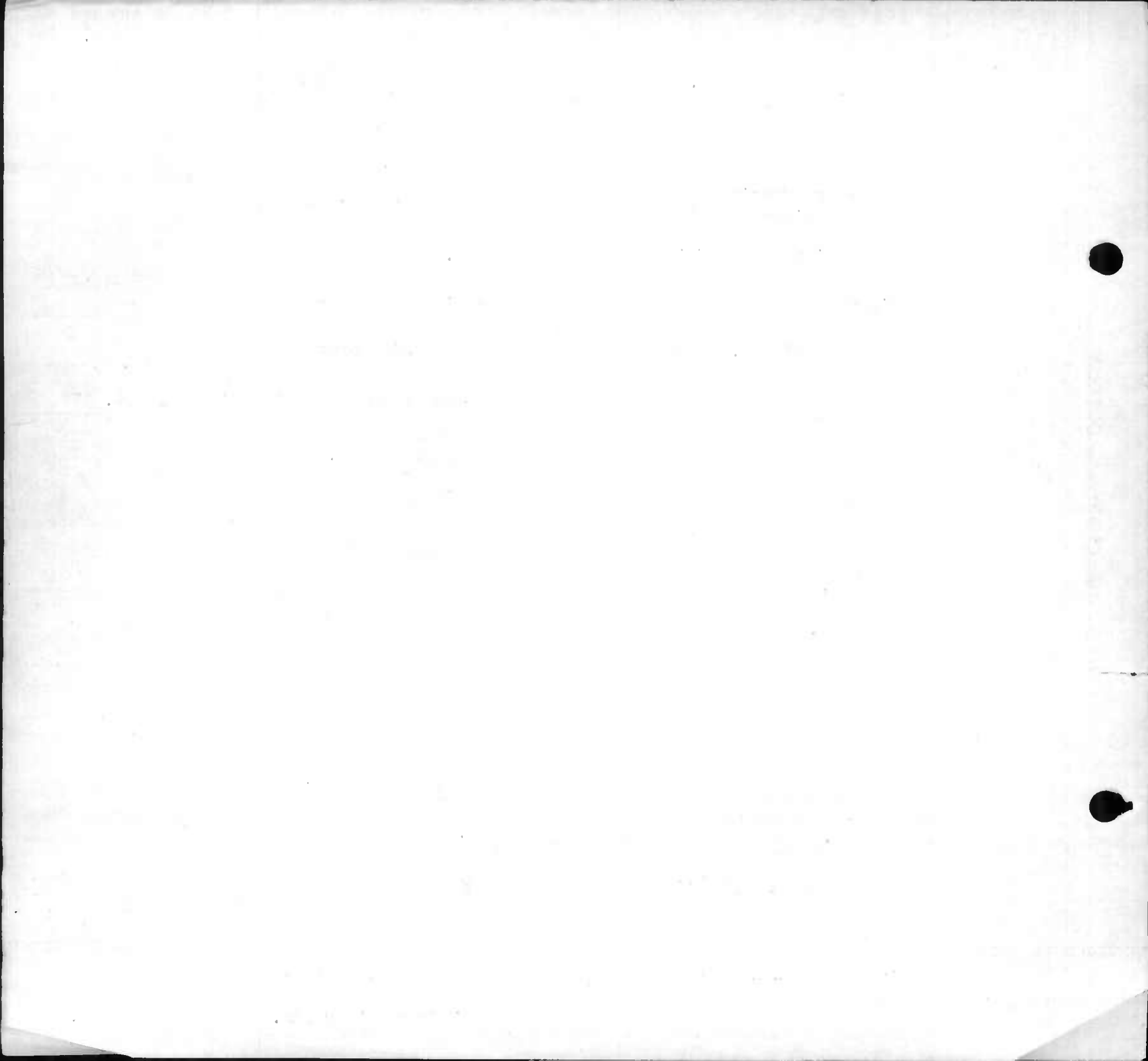
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4562</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>65 4562</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
M.E. CASE NO. 1. NAME OF DECEASED (Type in Print) <u>Maggie Fields</u>			2. DATE AND HOUR OF DEATH <u>4/24/65</u> <u>11</u> <u>45</u> <u>P</u> M.		
3. PLACE OF DEATH (IN BALTIMORE, MARYLAND)  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>Baltimore, Md</u>			4. USUAL RESIDENCE (Where deceased lived. (If institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>City</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>202 N. Fremont Ave</u>		
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>1879</u>	9. AGE (In years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>unknown</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Charles Marshall</u> ADDRESS <u>430 E 70th St</u>		
18. <u>154X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>possible pulmonary embolism</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Ca of rectum</u>					
19A. DATE OF OPERATION <u>3/4/8/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of rectum</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/1/65</u> 19 to <u>4/24</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert M. Byers</u>				23B. DATE SIGNED <u>4/24/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert M. Byers</u>				23D. ADDRESS <u>M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/1/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cemetry</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u> ADDRESS <u>918 Druid Hill Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4563</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4563</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">George G. Nelson</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Apr. 28, 1965</span> <span style="font-size: 1.2em;">4:00 a.m.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">Crowford Nursing Home 2117 Denison Street</span>		(If not in hospital or institution, give street address or location)		A. STATE <span style="font-size: 1.2em;">Maryland</span>		B. COUNTY <span style="font-size: 1.2em;">15-47</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2117 Denison Street</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">WIDOWED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Sept. 26, 1880</span>		9. AGE (in years last birthday) <span style="font-size: 1.2em;">84</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="font-size: 1.2em;">Peter W. Nelson</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Addie Garland</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Thomas Nelson Oakleigh Village, Apt. 370</span>			
18. <span style="font-size: 1.2em;">332X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cerebral thrombosis</span> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">7 days</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> Work Not White <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/9</span> 19 <span style="font-size: 1.2em;">63</span> to <span style="font-size: 1.2em;">4/28</span> 19 <span style="font-size: 1.2em;">65</span> . that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/26</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Robert A. Reiter</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/28/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert A. Reiter</span>				23D. ADDRESS <span style="font-size: 1.2em;">606 Edmondson Ave Balto 28</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-1-1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 29 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farber, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Lilly &amp; Zeiler Inc.</span>		ADDRESS <span style="font-size: 1.2em;">1901 Eastern Ave.</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4564		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4564	
1. NAME OF DECEASED (Type or Print) <b>LOCHNER, GEORGE JOHN</b>			2. DATE AND HOUR OF DEATH <b>APRIL 24, 1965 11:00 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>TOWSON 53300</b> D. STREET ADDRESS (If rural, give location) <b>414 ALABAMA ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8/14/91</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE J. LOCHNER SR</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET STEINBERGER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>212-07-7526</b>	17. INFORMANT ADDRESS <b>Hospital Records</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>- - - -</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 14 1965</b> to <b>APRIL 24 1965</b> , that (I) (we) last saw the deceased alive on <b>APRIL 24 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Chi-Tsung Su</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/24/65</b>
23C. PHYSICIAN'S NAME (Type) <b>CHI-TSUNG, SU</b>			23D. ADDRESS <b>M.D.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1965 April 28</b>	24C. NAME of CEMETERY or CREMATORY <b>Monte Maria, Towson, Md.</b>		24D. LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson, M.D.</b>		25C. FUNERAL DIRECTOR <b>William Cook-Brooks, Towson, 1050 York Road, Towson, Maryland 21204</b>	

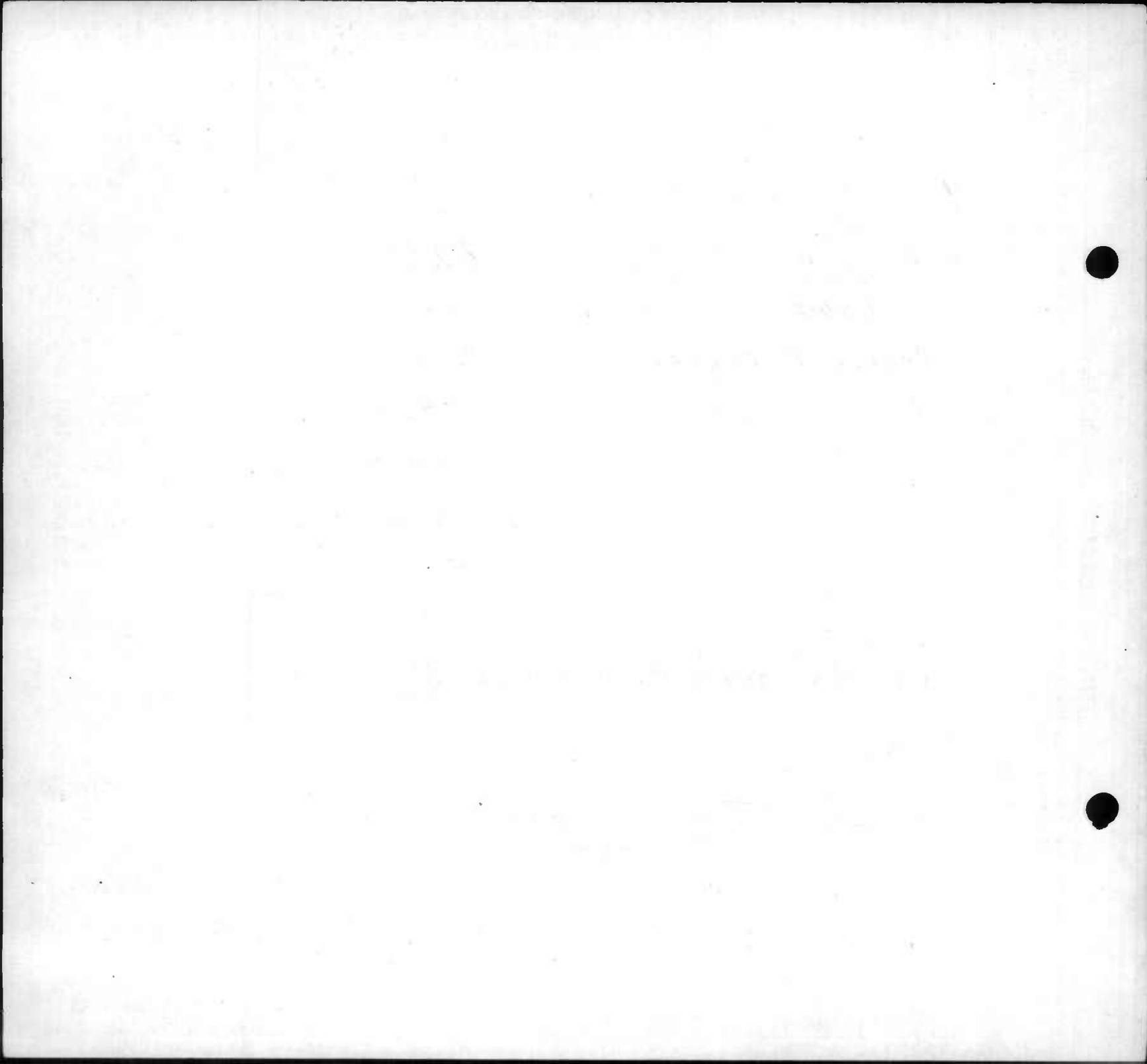
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# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
C-640					CERTIFICATE OF DEATH				
BIRTH NO. 65 4565					Registered No. 65 4565				
1. NAME OF DECEASED (Type or Print) <u>CURRELL, MARGARET CARTER</u>					2. DATE AND HOUR OF DEATH <u>4/25/65</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>VA.</u> B. COUNTY <u>V-43</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>KILMARNOCK</u>				
					D. STREET ADDRESS (If rural, give location) <u>—</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>6/2/90</u>	9. AGE (In years last birthday) <u>74</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>COLVIN P. CARTER</u>					14. MOTHER'S MAIDEN NAME <u>MARY P. GOULDIN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>UMH CHART</u>		
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ACUTE MYOCARDIAL INFARCTION</u>					<u>5 days</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ARTERIOSCLEROTIC HEART DISEASE</u>					<u>MANY YEARS</u>				
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION <u>4/24/65</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>THORACENTESIS - PLEURAL EFFUSION</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>—</u>			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>4/22/1965</u> to <u>4/25/1965</u> , that (I) (we) last saw the deceased alive on <u>4/25/1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>O. Laird Bryson</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4/25/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>O. LAIRD BRYSON</u>					23D. ADDRESS M.D. <u>UNION MEMORIAL HOSPITAL</u>				
24A. MANNER OF REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>4-27-65</u>			24C. NAME OF CEMETERY or CREMATORY <u>WHITE STONE METHODIST</u>			24D. LOCATION (City, town, or county) (State) <u>WHITE STONE, VIRGINIA</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Faldut</u>			25C. FUNERAL DIRECTOR <u>W.M. COOK BROOKS TOWSON 1050 YORK RD TOWSON, MD.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4566	
65 4566				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		ALEXANDRA HOBBS		4-24-65 12 50 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		MD 6-05	
CHURCH HOME & HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
D. STREET ADDRESS (If rural, give location)		CHURCH HOME & HOSPITAL - HOME		HOME	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
F	W	Widowed	5/3/87	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
UNEMPLOYED				VA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
GEORGE GRAYSON		ELIZA WEST		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) ACUTE CARDIAC ARREST		FEW HRS	
ANTECEDENT CAUSES		(B) MYOCARDIAL INFARCTION		DAYS	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) GENERALIZED ARTERIO-SCLEROSIS		YEARS	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 65 to 4/25 19 65, that (I) (we) last saw the deceased alive on 4/25/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ephraim B. Barzaga M.D.				4/25/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
EPHRAIM B. BARZAGA M.D.				CHURCH HOME & HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		4-26-65		Mt. OLIVET	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
FREDERICK, MARYLAND		WM COOK - BROOKS		TOWSON 1050 YORK RD TOWSON MD 21204	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. NAME OF REGISTRAR	
APR 29 1965		Robert E. Taylor, M.D.			

George Graham

unemployed

1000

1000

1000

1000

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1000

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1000

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1000

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1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH								Registered No. 65 4567			
BIRTH NO. 65 4567		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LE MIEUX, Lillian R.				2. DATE AND HOUR OF DEATH April 25, 1965 7:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  St. Joseph's Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21222 D. STREET ADDRESS (If rural, give location) 2 Township Road					
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH February 1, 1884		9. AGE (In years last birthday) 81		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Peru, Indiana				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME RAUER						14. MOTHER'S MAIDEN NAME JOSEPHINE FOGEL SONG					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSPITAL RECORDS					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterioscleotic heart disease (A) DUE TO Senility INTERVAL BETWEEN ONSET AND DEATH  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 8, 1965 to April 25, 1965, that (I) (we) last saw the deceased alive on April 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE S. Viriyapongse						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 25, 1965			
23C. PHYSICIAN'S NAME (Type) Sukho Viriyapongse						23D. ADDRESS M.D. 1400 N. Caroline Street					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE April 28, 1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1965				25B. NAME OF REGISTRAR Robert E. Fairley				25C. FUNERAL DIRECTOR William Cook-Brooks, Towson			

Page 2

John W. Foster  
Nov 18 1864

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4568					CERTIFICATE OF DEATH				
BIRTH NO.					Registered No. 65 4568				
1. NAME OF DECEASED (Type or Print) <b>Oaks, Myrtle</b>					2. DATE AND HOUR OF DEATH <b>4/26/65 12:50 pm</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 19, Sparrows Point</b> D. STREET ADDRESS (If rural, give location) <b>708 E. St.</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>3/26/1892</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>CHARLES MCGEE</b>					14. MOTHER'S MAIDEN NAME <b>THEODOSIA MCKENNEY</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS <b>Daughter, Mrs. Jane Reed, 2915 Ross Rd. 21219</b>				
18. CAUSE OF DEATH <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>XXXXX</b> DUE TO  ANTECEDENT CAUSES <b>XXXXX</b> DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>XX Myocardial Infarction</b>					INTERVAL BETWEEN ONSET AND DEATH  <b>1 day</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>XXXXXX</del> ) attended the deceased from <b>4/26</b> 19 <b>65</b> to <b>4/26</b> 19 <b>65</b> , that (I) ( <del>no</del> ) lost saw the deceased alive on <b>4/26</b> 19 <b>65</b> and that in (my) ( <del>my</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>John F. Bigger, Jr. M.D.</b>								23B. DATE SIGNED <b>4/26/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>John F. Bigger, Jr., M.D.</b>					23D. ADDRESS <b>Johns Hopkins Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>April-29-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Eastern Ave. Bal. Co. Md. 21224</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>			25C. FUNERAL DIRECTOR'S ADDRESS <b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>			

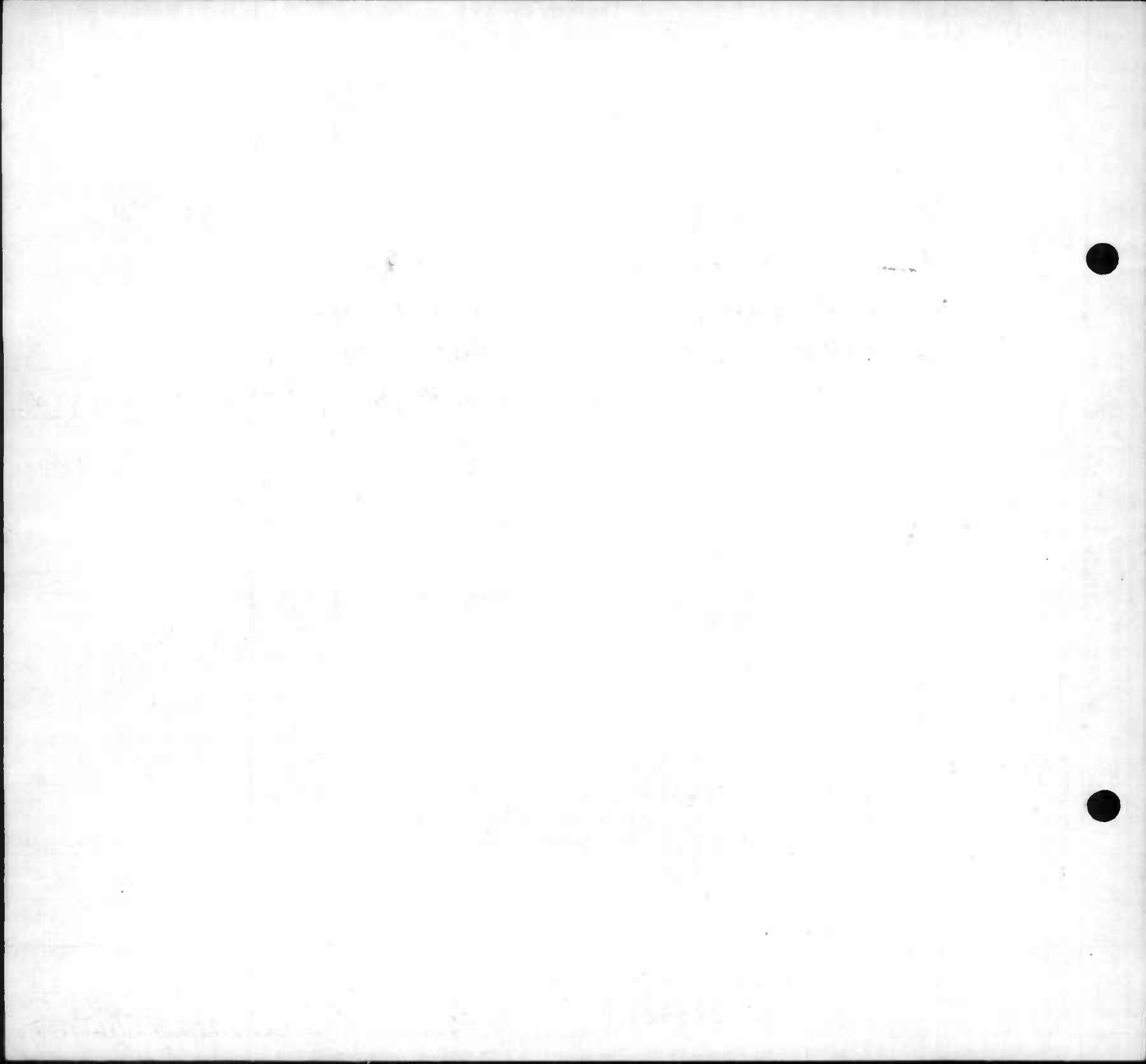
XXX



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4569		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4569	
1. NAME OF DECEASED (Type or Print) <b>Klemm Harry</b>			2. DATE AND HOUR OF DEATH <b>4-25-65 1208 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St Agnes Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>20-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2045 F. urrow St #23</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>1-30-96</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION ENGINEER</b>			11. BIRTHPLACE (State or foreign country) <b>BALTO., MD.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>GEORGE KLEMM</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE MOAN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>578-01-6593</b>	17. INFORMANT ADDRESS <b>MRS VERA F. KLEMM 209 FURROW ST</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>451X I Ruptured abdominal aneurysm</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Prob 24 hrs</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>ARTERIOSCLEROSIS</b> (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<b>Auricular Fibrillation ?</b> <b>CONGESTIVE HEART FAILURE</b>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4/24 1965</b> to <b>4/25 1965</b> , that (I) (we) last saw the deceased alive on <b>12:15 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ralph V. Ramirez</b>			M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>4/25/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ralph V. Ramirez</b>			23D. ADDRESS <b>3300 WILKENS AVE, BALTO</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-28-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>LOUDON PARK</b>	24D. LOCATION (City, town, or county) <b>BALTIMORE</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 20 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>	25C. FUNERAL DIRECTOR <b>Frank A. Cole</b> ADDRESS <b>1913 W. BALTA. ST</b>		



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Sedrick J. Travis

2. DATE AND HOUR PRONOUNCED DEAD

April 25, 1965

7:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

416 N. Green Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

416 N. Green Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

divorced

8. DATE OF BIRTH

9/19/1905

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

element

10B. KIND OF BUSINESS OR INDUSTRY

Merchant Marine

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Travis

14. MOTHER'S MAIDEN NAME

Maggie Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

1/8/22 to 1/7/25

16. SOCIAL  
SECURITY NO.

215-05-5793

17. INFORMANT

Oliver D. Travis - 1332 Sargent St (23)

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hemorrhage  
DUE TO

ruptured aortic aneurysm

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 25, 1965

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/29/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1965

24B. NAME OF REGISTRAR

Robert E. Parker

24C. FUNERAL DIRECTOR

John J. Cowan, Jr. Inc.

ADDRESS

901 Station St (23)

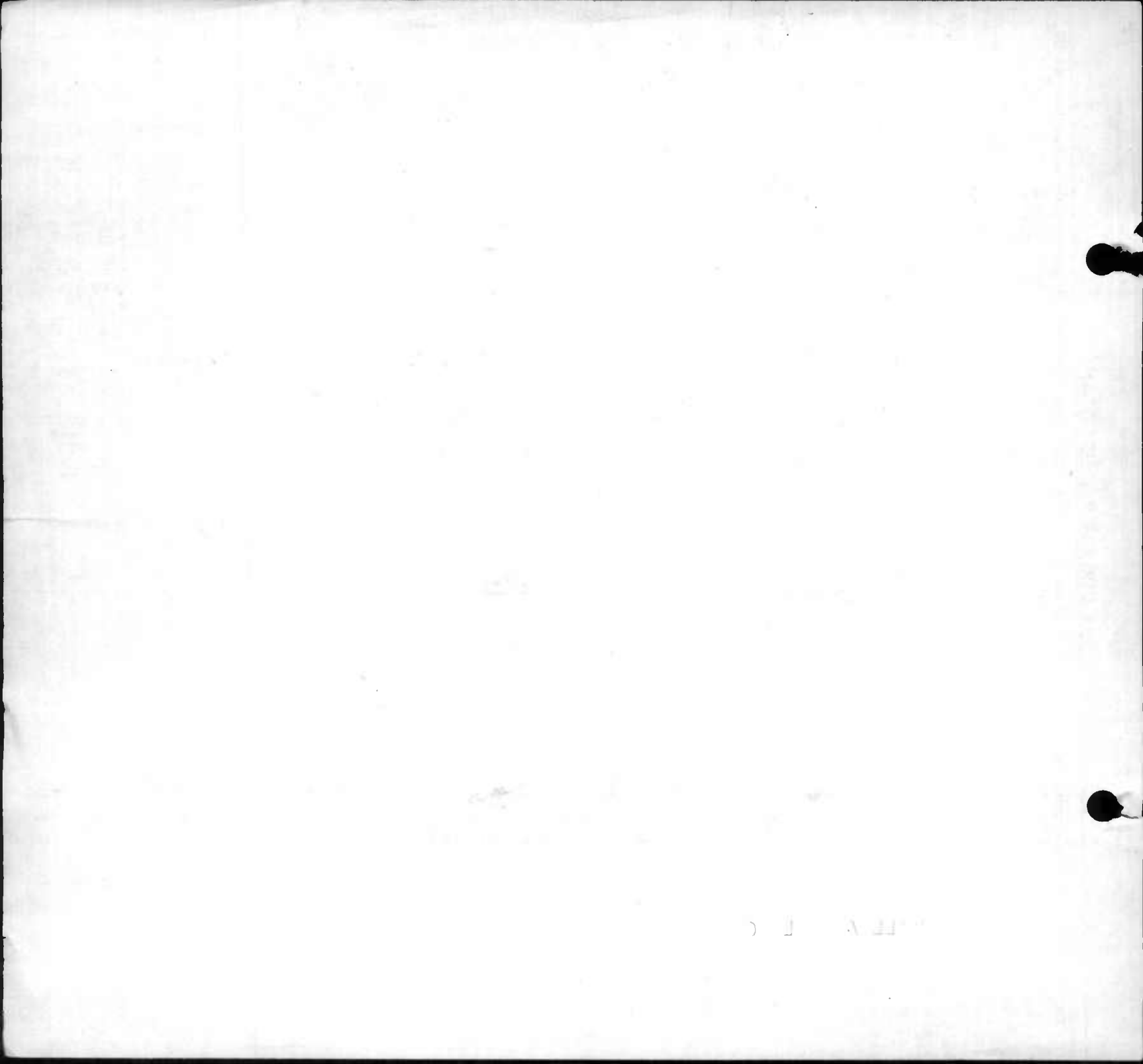
WALTER E. BROWN

U.S.A. 100-100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

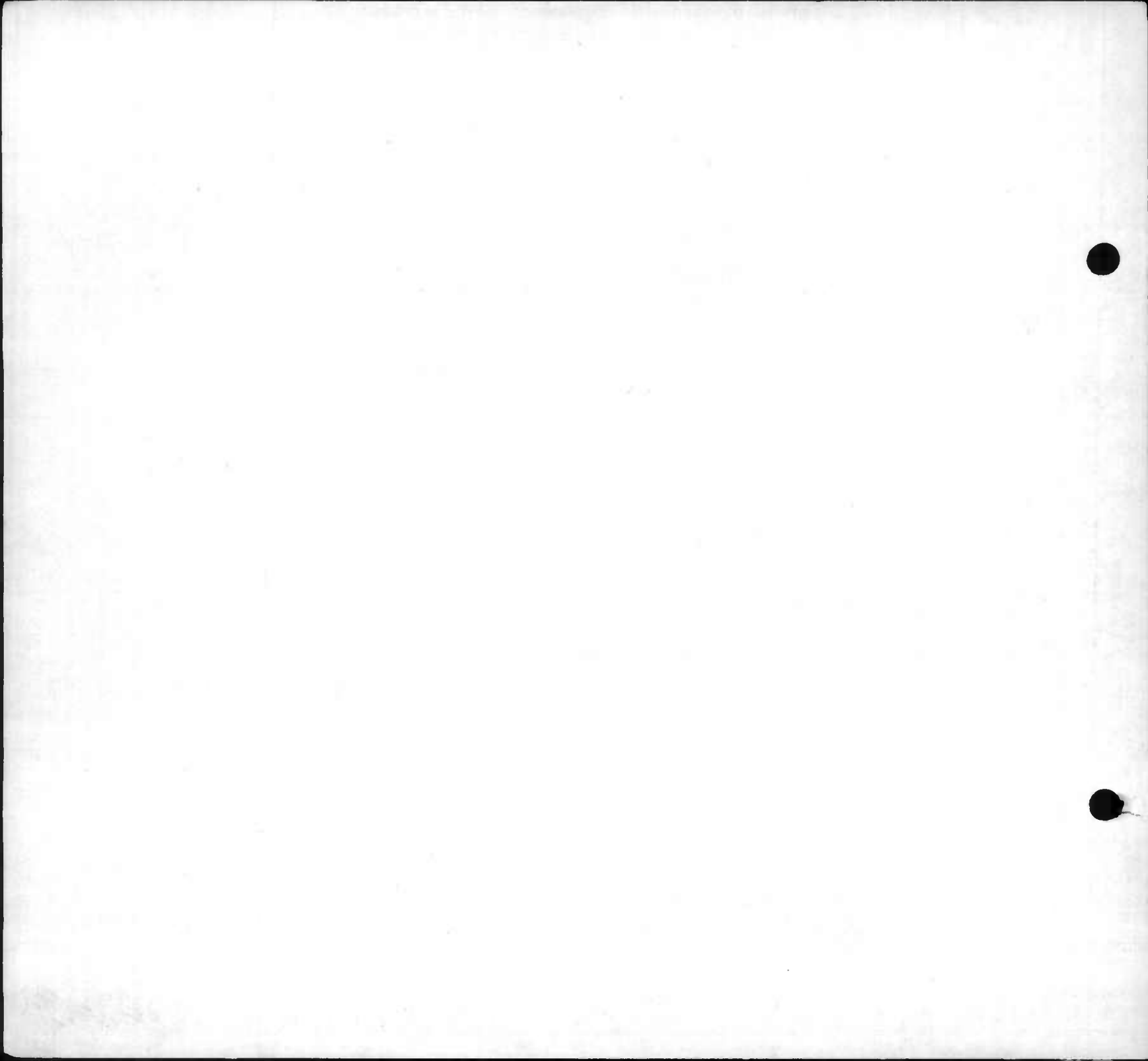
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 65 4571	
BIRTH NO. 65 4571		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dennis M. Sherby		2. DATE AND HOUR OF DEATH 4/25/65 11:25 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital				A. STATE Md		B. COUNTY 36-01	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 4401 Glenarm Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 9/5/51	9. AGE (In years last birthday) 13	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Darrell Sherby				14. MOTHER'S MAIDEN NAME Doris Ackerman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Darrell Sherby		ADDRESS Jame	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) Carcinoma matosis		2 mos	
				(B) Adenocarcinoma of the appendix		unknown	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 2/8/65 19 65 to 4/25 19 65, that (we) last saw the deceased alive on 4/25 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE William B. Long				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/25/65	
23C. PHYSICIAN'S NAME (Type) WILLIAM B LONG				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/65		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1965		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Mr. Neumann		ADDRESS 6667 Haydon Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 4572</b>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. <b>65 4572</b>	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>James Michael LeVERTON Jr.</b>			
2. DATE AND HOUR OF DEATH <b>4-27-65 2:00 P.M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>HOSPITAL For The Women of MARYLAND</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>6003 Burgess Ave.</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-13-04</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
13. FATHER'S NAME <b>James Michael LeVERTON Sr.</b>			14. MOTHER'S MAIDEN NAME <b>MAUDE LeVERTON</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>PATIENTS CHART</b>		
18. <b>42011</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Massive myocardial infarction 2° HYPERT.</b> (B) (C)  INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> 19 <b>65</b> to <b>4-27</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-27</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Agustín G. España</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-27-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALBECITA NPACIS</b>				23D. ADDRESS <b>Woman's Hosp. Balto 17. Wd.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mountland Mem</b>		24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>PA Heimann</b>		ADDRESS <b>6067 Hayford Rd</b>	





BIRTH NO.

65

4572

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

4573

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ALICE WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

17 April 1965

7:30 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Prince George's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Laurel

D. STREET ADDRESS (If rural, give location)

Rt. 5 Box 27

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED ☒  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

3/17/93

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

John Williams

14. MOTHER'S MAIDEN NAME

Sarah Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Sarah E. Hall: Item # 2

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/18/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/21/65

23C. NAME of CEMETERY or CREMATORY

Bacontown

23D. LOCATION

(City, town, or county)

(State)

Laurel, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 20 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Robert L. Snowden

ADDRESS

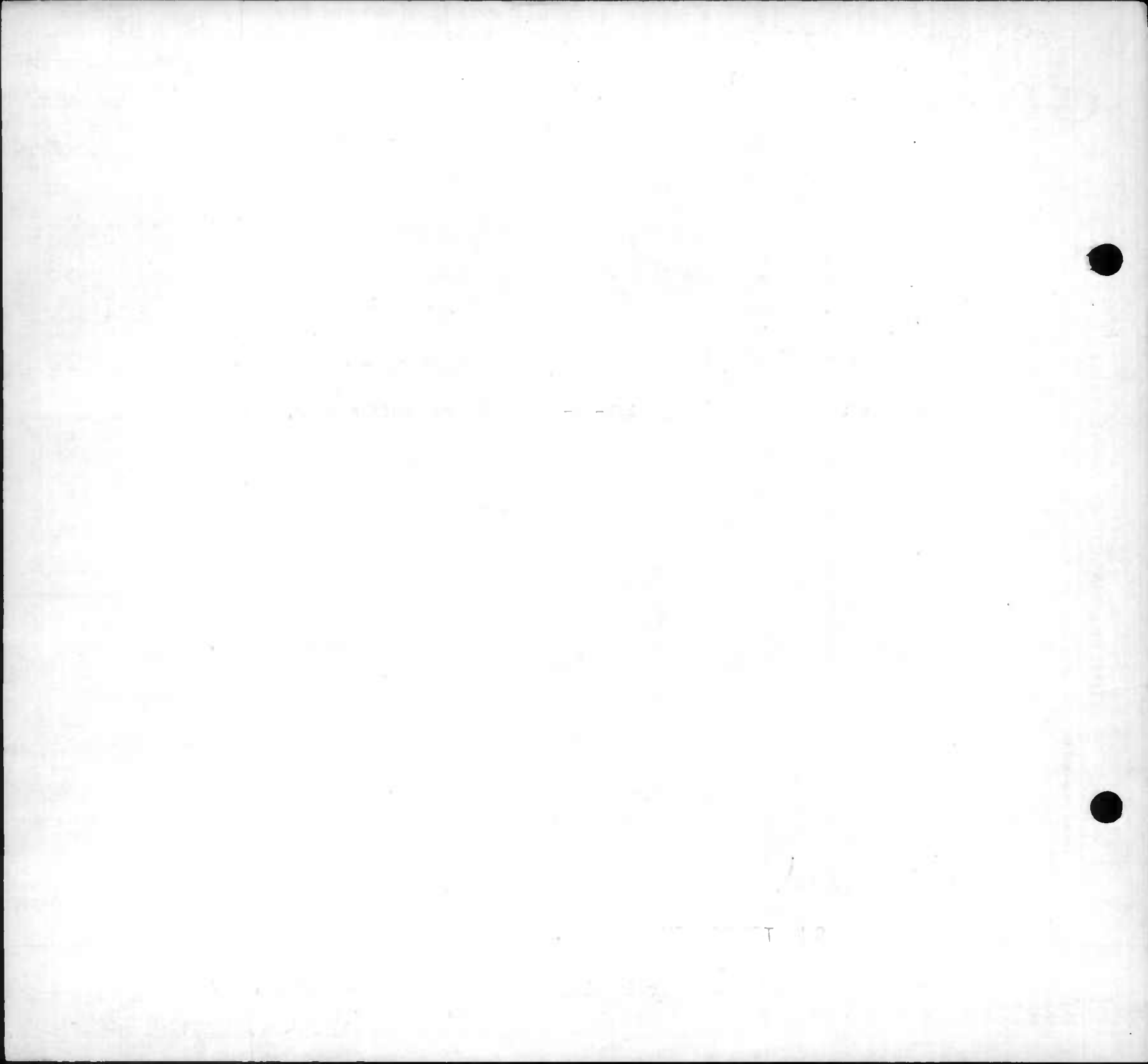
Rockville, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

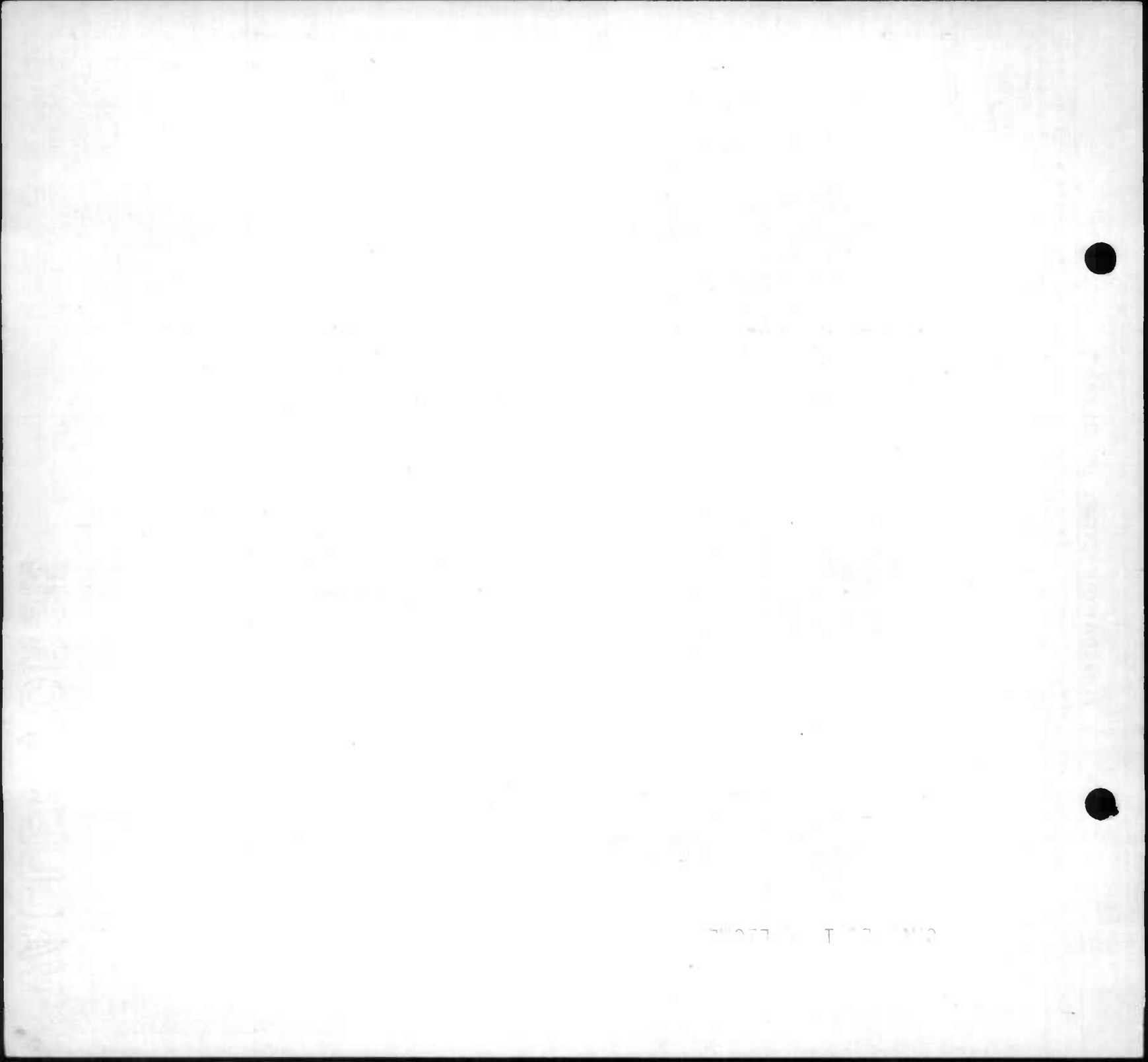
BIRTH NO. 65 4574		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4574	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BITTER, KENNETH OSCAR		2. DATE AND HOUR OF DEATH APRIL 24 1965 5:45 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00			
		D. STREET ADDRESS (If rural, give location) 523 WILTON ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 10-2-97	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME OSCAR BITTER			
14. MOTHER'S MAIDEN NAME ELENORE POSKE		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 212-01-2581		17. INFORMANT Mildred Duff Bitter, 523 Wilton Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Carcinoma of Lung with Metastasis to Body (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 4.19.65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BIOPSY		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 15 1965 to APRIL 24 1965, that (I) (we) last saw the deceased alive on APRIL 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chi Tsung, Su		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/24/65	
23C. PHYSICIAN'S NAME (Type) CHI TSUNG, SU		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/28/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge	
24D. LOCATION Baltimore, Maryland		24E. STATE (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1965		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR William Cook-Brooks, Inc. HB	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 4575</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 4575</b>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Charles S. Jackson</b>			<b>April 27 1965 11:20 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>27-11</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>101 Overhill Rd.</b>		
5. SEX <b>Male</b>	6. RACE <b>Caucas</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Married</b>	8. DATE OF BIRTH <b>8-22-89</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Commissioner (retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Gardner Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gardner Shattuck</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1904-1911 + 1916-1919-041-22-122</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Carroll Jackson 332 Tyrone Circle</b>	
18. <b>4-20-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> <b>Congestive heart failure</b> <b>Coronary heart disease, severe</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>April 5 1965</b> to <b>April 27 1965</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 25 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Charles T. Fletcher</b> M.D.				23B. DATE SIGNED <b>April 27 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHARLES T. FLETCHER</b>				23D. ADDRESS <b>Union Memorial Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial April 28 1965 - Laurel Ridge - Ballto 2/208</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <b>APR 28 1965</b>		25B. NAME OF REGISTRAR <b>W. E. Fisher M.D.</b>	
25C. FUNERAL DIRECTOR <b>Shewash Monro 108 W 7th</b>		25D. ADDRESS		25E. ADDRESS	



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Gilman E. HOFFMAN

2. DATE AND HOUR PRONOUNCED DEAD

4-25-65

6:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2631 Hampden Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 12, 1898

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Instant Whip Co

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Jefferson Hoffman.

14. MOTHER'S MAIDEN NAME

Helen G. /?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen G. Hoffman, 2631 Hampden Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease or  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-26-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/29/65

23C. NAME OF CEMETERY or CREMATORY

Meadowridge

23D. LOCATION

(City, town, or county)

(State)

Wash. Blvd, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 29 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Christine E. Honohan 3818 Roland Ave

ADDRESS



Notified  
Jellerson Holman.  
Instant with Co. Maryland  
Aug 12, 1898  
Helen G. /  
Helen J. Holman. 2821 Hampton Ave

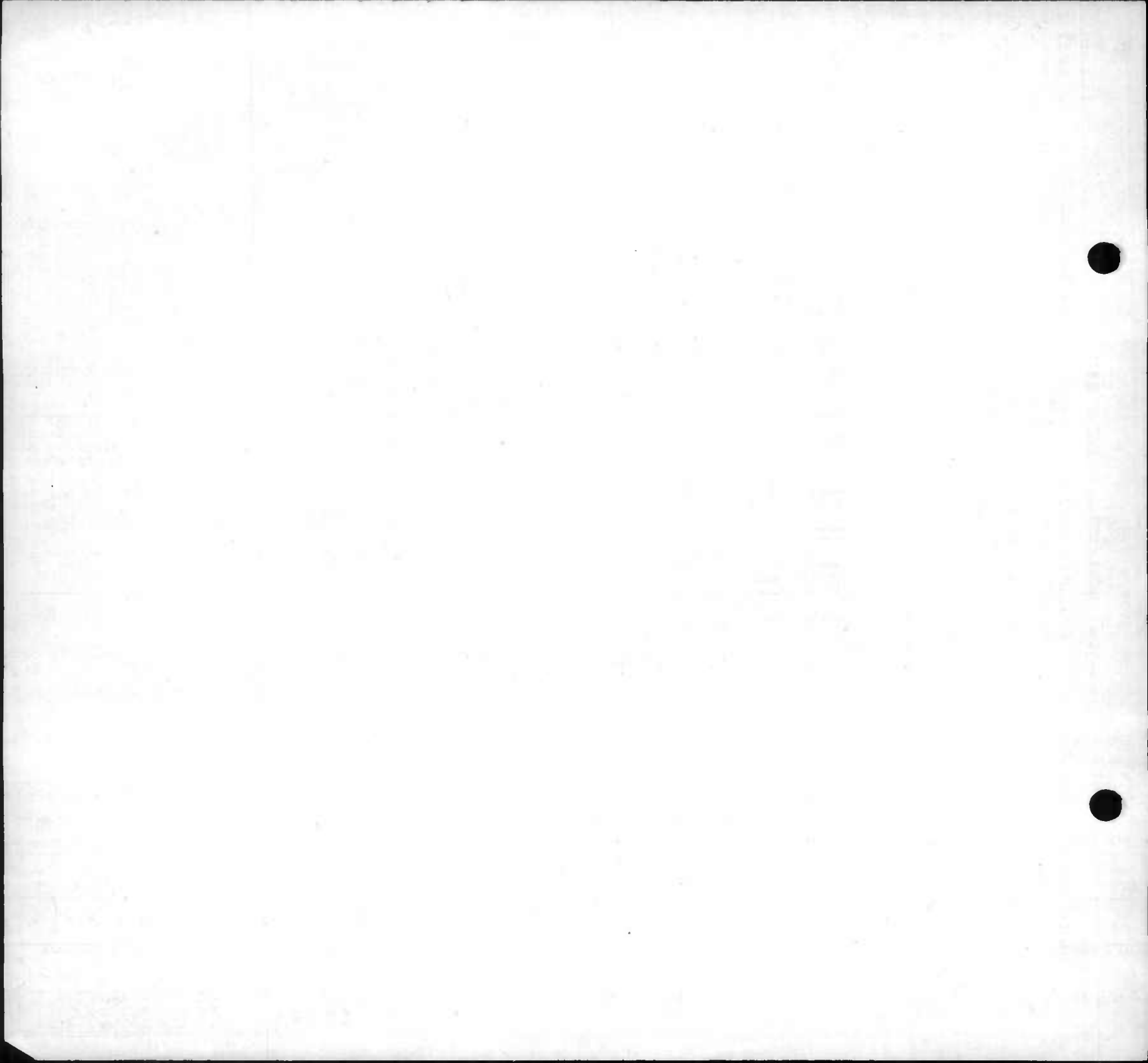
Smith 1/20/65 Newtownships Wash. Blvd. Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

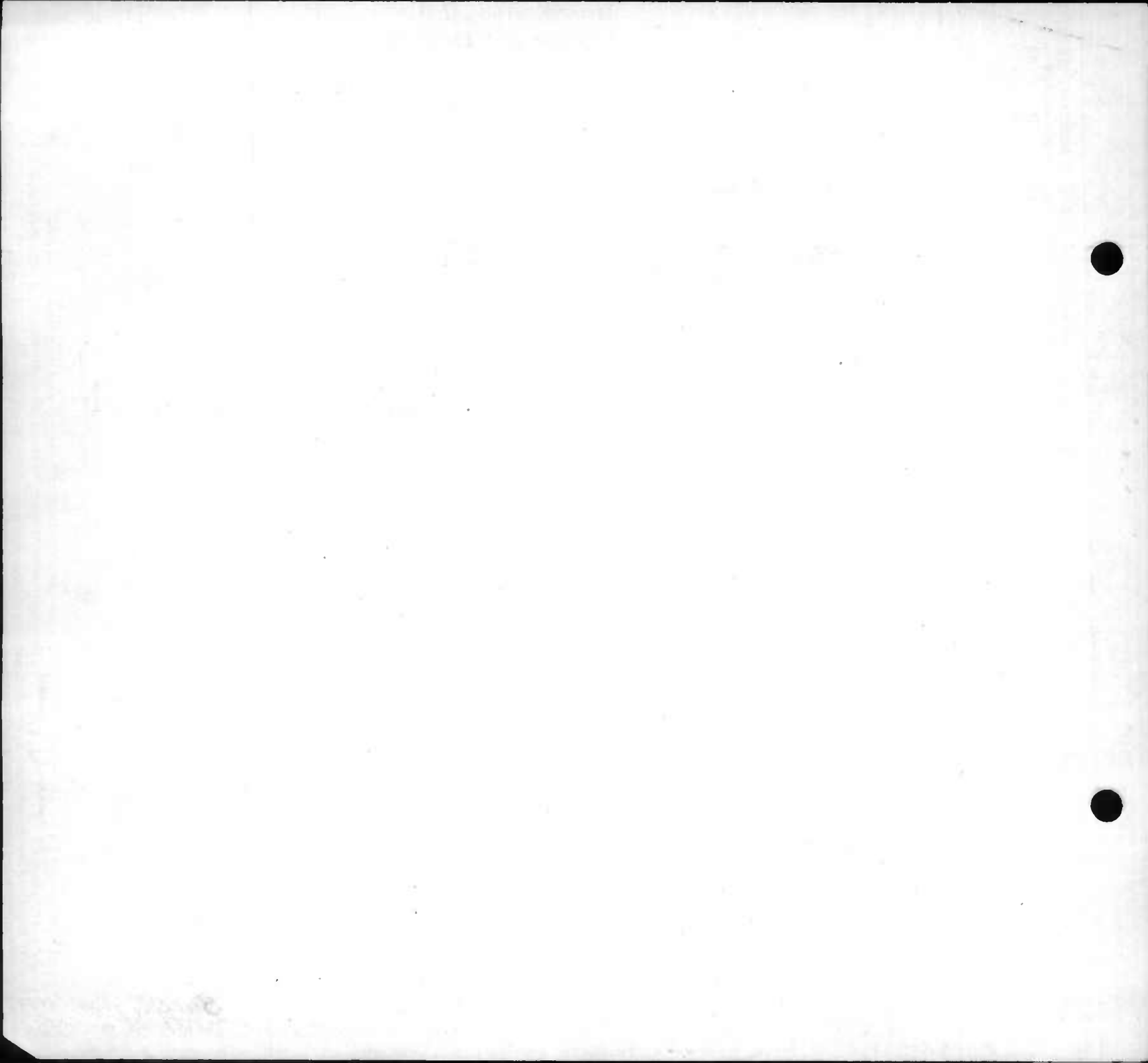
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4577					CERTIFICATE OF DEATH		Registered No. 65 4577		
1. NAME OF DECEASED (Type or Print) <b>FRIDA E. HARRISON</b>					2. DATE AND HOUR OF DEATH <b>4-27-65 6:45 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CHURCH HOME + HOSPITAL</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>5-04</b>				
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>					8. DATE OF BIRTH <b>5-26-93</b>		9. AGE (In years last birthday) <b>71</b>		10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>WILLIAM LINNEMANN</b>					14. MOTHER'S MAIDEN NAME <b>ELISA ALVERS</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <b>212-05-8687</b>		17. INFORMANT <b>CHARLOTTE RUHL</b> <b>1206 N. BRADFORD, BALTO 13</b>		
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolism</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					(A) DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <b>POST-WENTHEIM OPERATION</b> <b>6 days</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO <b>Adenocanthoma, uterus</b> <b>unknown</b>				
19A. DATE OF OPERATION <b>4-21-65</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Adenocanthoma uterus</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>4-10-65</b> 19 to <b>4-27-65</b> , that (I) (we) last saw the deceased alive on <b>4-27-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Edgardo G. Leonidas</b> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4-27-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDGARDO G. LEONIDAS</b>					23D. ADDRESS <b>Church Home + Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-30-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Frederick Rd. Balt Md</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Gandy</b>		25C. FUNERAL DIRECTOR <b>Paul Cook 17017 Patterson Blvd</b>		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

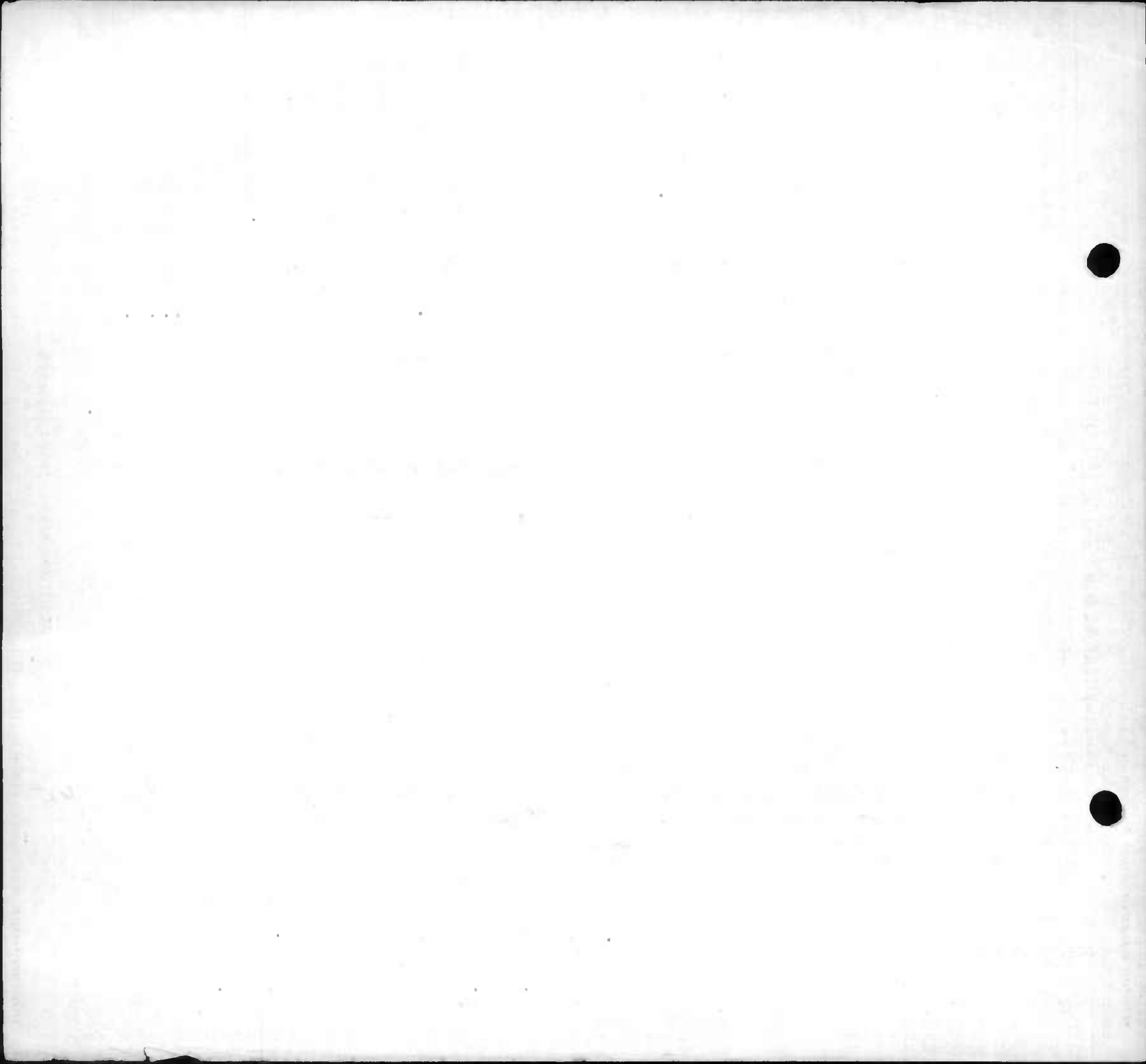
BALTIMORE CITY HEALTH DEPARTMENT				65 4578	
CERTIFICATE OF DEATH				Registered No. 65 4578	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Amelia J. Wirth		April 27, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland			
City Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 3413 Guilford Terrace 21218			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days
Female	White	Single	3/2/1885	80	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Never Worked				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Andrew J. Wirth			Margaretta Baals		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		3413 Guilford Terrace Mr. Harold Wirth Baltimore, Md. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
420.11-260X		(A) Myocardial infarction (acute) 10 minutes			
ANTECEDENT CAUSES		(B) Old myocardial infarction 16 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertension C.V. Disease 20 years			
II		Diabetes mellitus 25 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1940 to April 27, 1965, that (I) (we) last saw the deceased alive on April 27, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Chilmer Stewart				4/28/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
C. Wilbur Stewart				G.E. Read St. Baltimore 2 Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		4/29/1965		Loudon Park Crematory	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 29 1965		E. Fairbank		Wm. F. Fisher & Sons Baltimore, Md. 21217	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4579</u>	
BIRTH NO. <u>65 4579</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>April 26, 1965</u> M.			
1. NAME OF DECEASED (Type or Print) <u>LULA L. JONES</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-08</u>			
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4117 Mountwood Rd.</u>		D. STREET ADDRESS (If rural, give location) <u>4117 Mountwood Rd.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12/12/93</u>	9. AGE (In years last birthday) <u>71</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	
13. FATHER'S NAME <u>John Harcum</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>George Jones 4117 Mountwood Rd.</u>	
18. <u>442X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertension Cardiovascular - 4 yrs.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Renal Failure</u>		CAUSE OF DEATH (A) <u>Hypertension Cardiovascular</u> (B) <u>Renal Failure</u> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>24 Oct 1964</u> to <u>26 Apr 1965</u> , that (H) <u>lost</u> saw the deceased alive on <u>24 Apr 1965</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Simon H. Carter</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>24 Apr 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Simon H. Carter</u>		23D. ADDRESS <u>1272 Penna Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Arbutus, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1965</u>			
25B. NAME OF REGISTRAR <u>R. E. Farber</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George A. Kohn 1318 N. Calhoun St.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4580</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4580</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Virgie De Coursey</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4/28/65 1 11<sup>45</sup> A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">42 Sinai Hosp</span>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">27-18</span>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Balto</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">5213 Denmore Ave</span>			
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">W</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6/28/07</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">57</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">John T. DeCoursey</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Blanche Johnson</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Mistle Washington</span>		ADDRESS <span style="font-size: 1.2em;">5213 Denmore Ave</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">172X I Adenocarcinoma of Endometrium</span>				CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4 mo.</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-27-64</span> to <span style="font-size: 1.2em;">1-3</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/21</span> 19 <span style="font-size: 1.2em;">65</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Lawrence Solomon</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/28/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">LAWRENCE Solomon</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">Sinai Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <span style="font-size: 1.2em;">5-1-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Auburn Cem</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 29 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Henry H. Kline</span>			
				ADDRESS <span style="font-size: 1.2em;">1348 N. Calhoun St</span>			

100  
The 1st of June  
at the Hotel

John F. Kennedy

John F. Kennedy  
at the Hotel

100  
The 1st of June  
at the Hotel

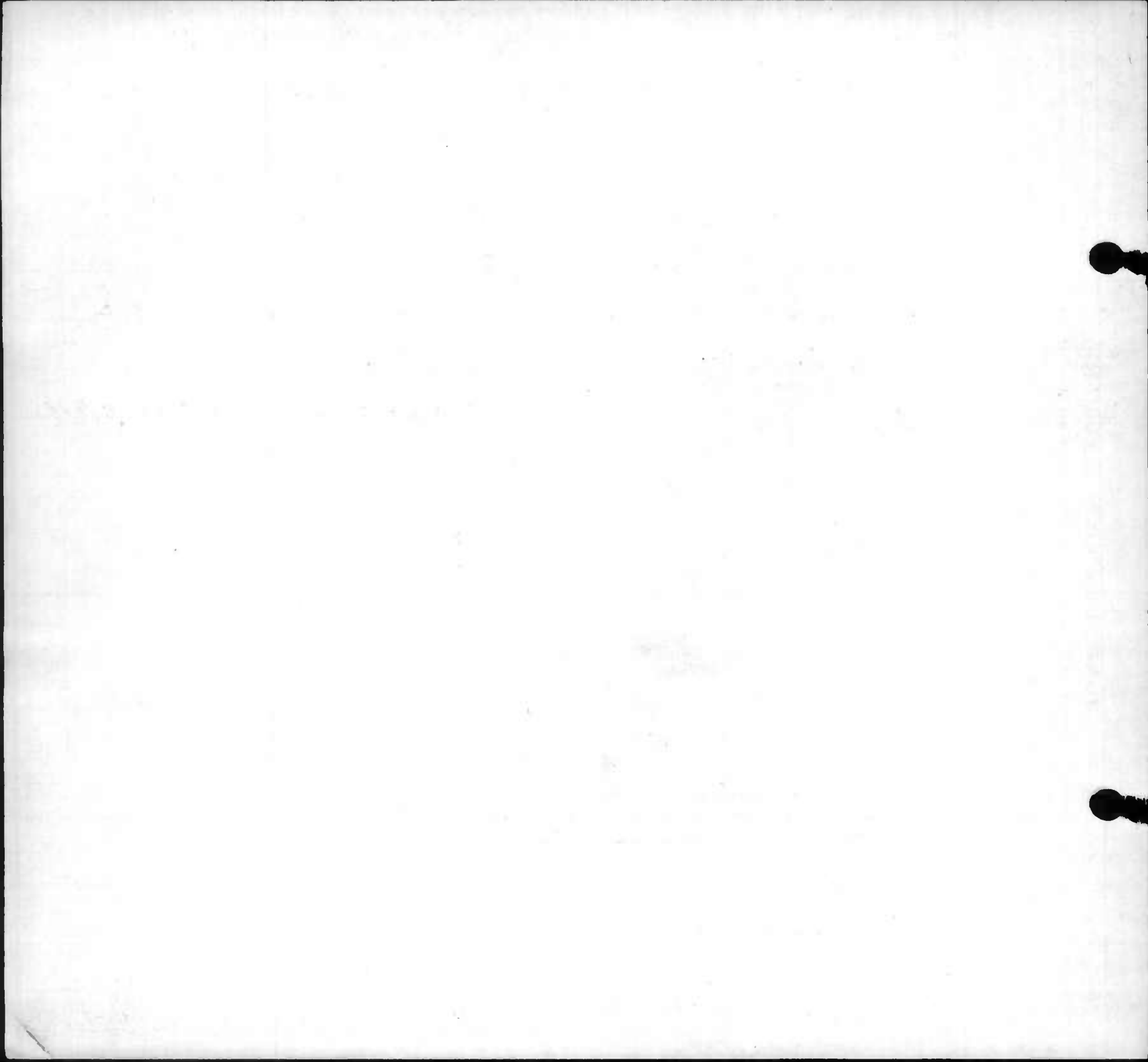


FUNERAL DIRECTOR: IMPORTANT

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L3001

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4581</b>	
BIRTH NO. <b>65 4581</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mary Gertrude Lloyd</b>		2. DATE AND HOUR OF DEATH <b>4-25-65 9:00 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-08</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2004 Homewood Ave.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2004 Homewood Ave.</b>			
5. SEX <b>Female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>2-12-1900</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's Co., Md.</b>	
13. FATHER'S NAME <b>Henry Briscoe</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wayland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-32-1503</b>		17. INFORMANT <b>Henry Lloyd 2004 Homewood Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>744XVI 260X</b>		CAUSE OF DEATH (A) <b>Congestive Heart Failure</b> (B) <b>Arteriosclerotic Heart Disease</b> (C) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Aug 1962</b> to <b>April 1965</b> , that (I) <del>was</del> lost saw the deceased alive on <b>April 24, 1965</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>Was</del> (did) <del>did not</del> view the body after death.					
23A. SIGNATURE <b>Jesse T. Holmes</b>				23B. DATE SIGNED <b>4/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jesse T. Holmes</b>				23D. ADDRESS <b>508 E. North Ave. BALT. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-29-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>	
24D. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>			
25B. NAME OF REGISTRAR <b>R. E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Randolph Collick</b>			
25D. ADDRESS <b>1412 E. Preston St.</b>					



BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 4582

**BIRTH NO.** 65 4582

**M.E. CASE NO.** 65 4582

**1. NAME OF DECEASED** (Type or Print) Alice L. Doweller

**2. DATE AND HOUR PRONOUNCED DEAD** 4/23/65 3:15 p. M.

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)

**A. STATE** Maryland

**B. COUNTY** Baltimore

**C. CITY OR TOWN** (If outside corporate limits, write RURAL and give township) Baltimore

**D. STREET ADDRESS** (If rural, give location) 1912 W. Franklin St.

**5. SEX** female

**6. RACE** colored

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)** Married

**8. DATE OF BIRTH** 3-17-25

**9. AGE** (In years last birthday) 40

**10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Housewife

**11. BIRTHPLACE** (State or foreign country) Baltimore, Md.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A

**13. FATHER'S NAME** Henry Lloyd

**14. MOTHER'S MAIDEN NAME** Gertrude Briscoe

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) No

**16. SOCIAL SECURITY NO.**

**17. INFORMANT** Daniel Pinkney

**18. CAUSE OF DEATH** 1912 W. Franklin St.

**19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease

**20. ANTECEDENT CAUSES** (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.)

**21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** 0

**19B. CONDITION FOR WHICH OPERATION WAS PERFORMED**

**20A. AUTOPSY?** (Yes or No) no

**20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.**

**21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.)

**21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME OF INJURY** (Month) (Day) (Year) (Hour) (Approx.)

**21E. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐

**21F. HOW DID INJURY OCCUR?**

**22. I certify that I held on** Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

**ACTUAL SIGNATURE** Werner W. Spitz, M.D.

**EXAMINER'S NAME (Type)** W.U. Spitz, M.D.

**CHIEF MEDICAL EXAMINER** ☐

**ASSISTANT MEDICAL EXAMINER** ☐

**ASSOCIATE MEDICAL EXAMINER** ☒

**DATE SIGNED** 4/23/65

**23A. BURIAL CREMATION, REMOVAL (Specify)** Burial

**23B. DATE** 4-29-65

**23C. NAME OF CEMETERY or CREMATORY** Arbutus Mem. PK.

**23D. LOCATION** (City, town, or county) (State) Arbutus, Md.

**24A. DATE REC'D BY HEALTH DEPT.** APR 29 1965

**24B. NAME OF REGISTRAR** 00956-520-44

**24C. FUNERAL DIRECTOR** Rudolph J. Collick

**24D. ADDRESS** 1412 E. Preston St.

VALLEY BOULEVARD

PROBATION

James L. King

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

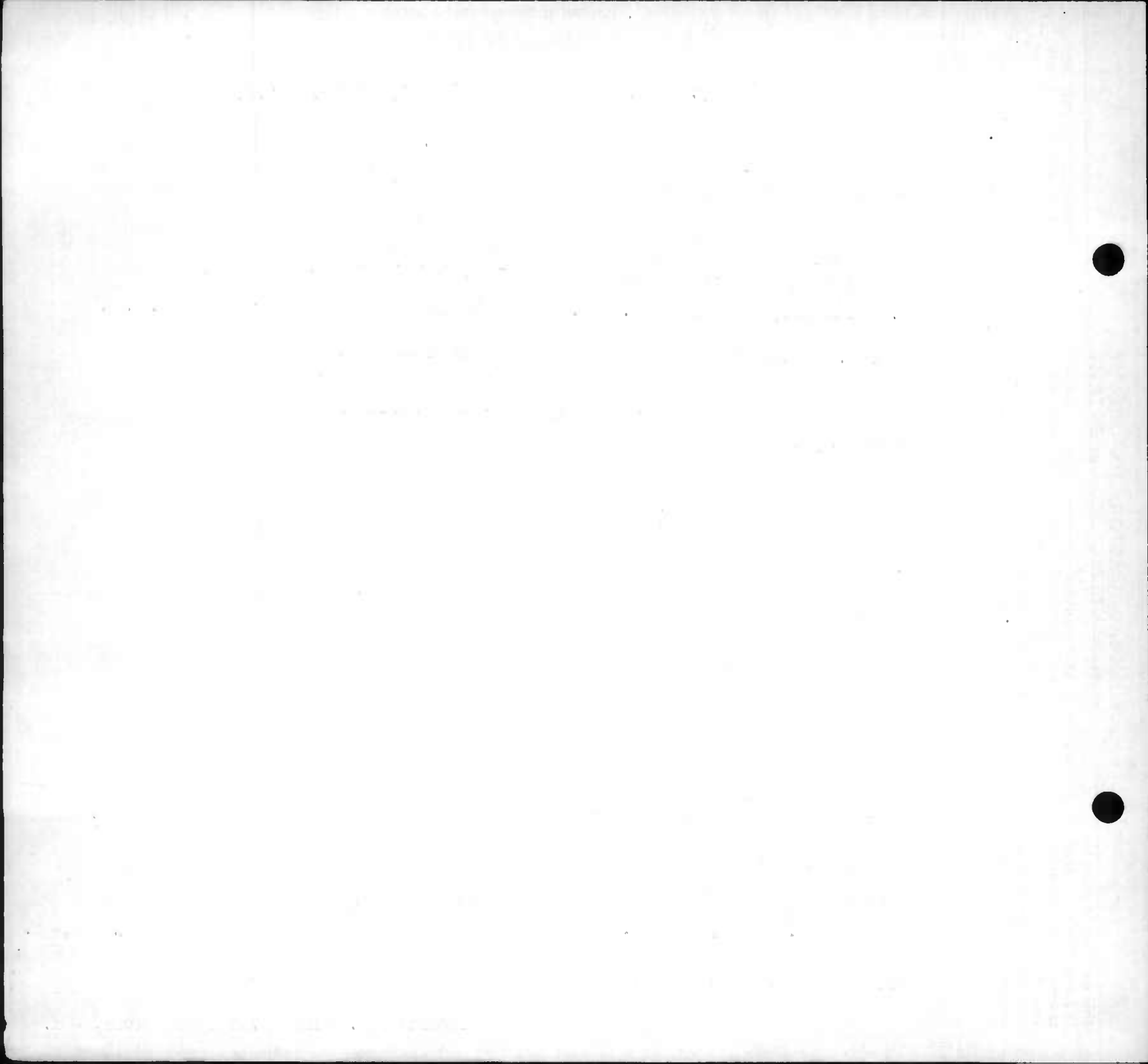
65 4583		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4583	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				2. DATE AND HOUR OF DEATH	
				3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street and house or lot number)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
MERCY HOSPITAL		4/30/65		A. STATE Maryland	
B. COUNTY		C. CITY OR TOWN		(If outside city limits, write RURAL and give township)	
D. STREET ADDRESS		(If rural, give location)		E. AGE (In years last birthday)	
259 S. Exeter St.		80		F. DATE OF BIRTH	
1-6-85		G. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		H. AGE (In years last birthday)	
married		80		I. CITIZEN OF WHAT COUNTRY?	
U.S.A.		J. BIRTHPLACE (State or foreign country)		K. CITIZEN OF WHAT COUNTRY?	
Atri-Italy		U.S.A.		L. FATHER'S NAME	
Leonardo Vecchetti		M. MOTHER'S MAIDEN NAME		N. SOCIAL SECURITY NO.	
Elisabetta Vecchetti		218-48-4405		O. INFORMANT ADDRESS	
Guy J. Matricciani		5109 N. Charles St.		P. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
Cerebral Hemorrhage		Q. INTERVAL BETWEEN ONSET AND DEATH		2 HOURS	
Chronic Pyelonephritis		20 years		R. ANTECEDENT CAUSES	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		S. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		T. MEDICAL CERTIFICATION	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19 45 to 4/27/65		23A. SIGNATURE		23B. DATE SIGNED	
that (I) (we) lost saw the deceased alive on 4/26/65		John R. Davis		4/27/65	
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
John R. Davis		MEDICAL ARTS BUILDING		24A. BURIAL CREMATION, REMOVAL (Specify)	
Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
4/30-65		Lorraine Park Mausoleum		24D. LOCATION (City, town, or county) (State)	
5608 Dogwood Rd Woodland Md.		25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
APR 29 1965		25C. FUNERAL DIRECTOR ADDRESS		25D. FUNERAL DIRECTOR ADDRESS	
322 S. High St.		Frank Della Noce		322 S. High St.	

vs 153 signed by funeral director. 4/30/65 cpb

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65-4584					65-4584				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <i>William J. Parrott</i>					2. DATE AND HOUR OF DEATH <i>April 27, 1965</i> <i>6:55 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>27-09</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>5204 Leith Road</i> D. STREET ADDRESS (If rural, give location) <i>Baltimore</i>				
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Feb 23, 1891</i>	9. AGE (In years last birthday) <i>74</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Stirling Steel Prod. Co.</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>John C. Parrott</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Heise</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>216077515</i>		17. INFORMANT <i>Rhea Parrott</i>		ADDRESS <i>same</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Coronary occlusion</i> DUE TO (B) <i>A-S heart disease</i> DUE TO (C) <i>5 min</i> <i>5 yrs</i>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>4/11</i> 19 <i>56</i> to <i>4/27</i> 19 <i>65</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>4/27</i> 19 <i>65</i> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <i>N. R. Freeman, Jr.</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/28/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Norman R. Freeman, Jr.</i>					23D. ADDRESS <i>11 West 29th Street, Balto. 18, Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/1/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i>		ADDRESS <i>Baltimore, Md.</i>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <u>65 4585</u>					
BIRTH NO. <u>65 4585</u>		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>Margaret Jenkins</u>			2. DATE AND HOUR OF DEATH <u>April 29 1965</u> <u>5 40</u> <u>A</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-06</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 14</u> D. STREET ADDRESS (If rural, give location) <u>6301 Pioneer Drive</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>		8. DATE OF BIRTH <u>3-26-94</u>	9. AGE (In years last birthday) <u>71</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>				10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Adam Beelat</u>					14. MOTHER'S MAIDEN NAME <u>Veronica Vaudagis</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT ADDRESS <u>Lawrence Abare 6301 Pioneer Drive.</u>				
18. <u>237X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <u>Cerebro-Vascular hemorrhage</u> <u>Probable tumor of the brain</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>NOT KNOWN</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>April 25</u> 19 <u>65</u> to <u>April 29</u> 19 <u>65</u> , that <u>(H)</u> (we) lost saw the deceased alive on <u>April 25</u> 19 <u>65</u> and that in <u>(M)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>J. Howard Lutz</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>April 27, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>J. HOWARD LUTZ</u>					23D. ADDRESS M.D. <u>Church Home Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/1/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Ruck</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc 5305 Harford Rd.</u>				

Charles H. H. H. H.

1874

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W

March 1st

March 1st

March 1st

March 1st

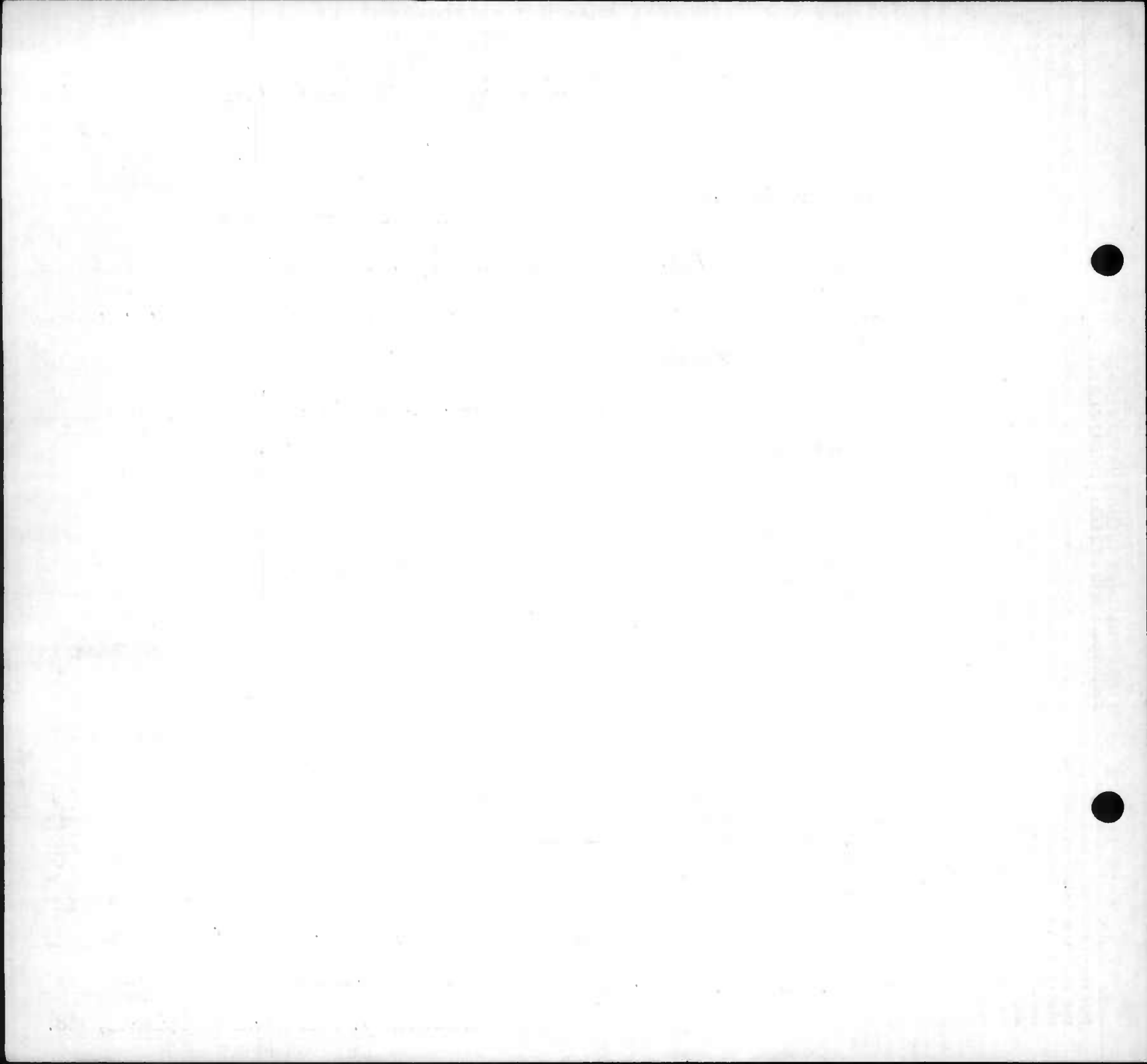
March 1st

March 1st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4586</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4586</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mary Hildwein</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 28, 1965 5:30 A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Gould Nursing Home</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">2702</span>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4705 Grindon Avenue</span>			
5. SEX <span style="font-size: 1.2em;">female</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) <span style="font-size: 1.2em;">widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">July 15, 1882</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">82</span>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Oversider</span>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220728002</span>		17. INFORMANT <span style="font-size: 1.2em;">Mrs. Emma Vavrina</span>		ADDRESS <span style="font-size: 1.2em;">same</span>	
18. <span style="font-size: 1.2em;">337X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">gen l arteriosclerosis hypertension</span>				CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">Hemorrhage artery brain due to arteriosclerosis</span> (B) DUE TO <span style="font-size: 1.2em;">Hypertension</span> (C) <span style="font-size: 1.2em;">Hypertension</span>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <span style="font-size: 1.2em;">July 15, 1959</span> to <span style="font-size: 1.2em;">April 28, 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/27/65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (had) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Dr. Fred W. Mintzer</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/29/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DONALD W. MINTZER</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">3009 EVERGREEN AVE BALTO MD</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/30/65</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Carmel Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 29 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. D. E. F. J. J. J.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Ruck Inc Baltimore, Md.</span>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4587				
BIRTH NO. 65 4587									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)		JANSON, CHARLES M.				2. DATE AND HOUR OF DEATH 4-26-65 9:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran hospital of Maryland.					A. STATE Maryland				
					B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27				
					D. STREET ADDRESS (If rural, give location) 5502 Main St.				
5. SEX male	6. RACE white	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 4-16-1893	9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Wm. Janson					14. MOTHER'S MAIDEN NAME Mary Anna Kirchner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-4371		17. INFORMANT Mr. Charles J. Janson-5502 Main St. ElkrIDGE Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Small intestinal fistula (B) vesico-vaginal fistula (C) retrograde urinary infection due to carcinomatous chronic				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-25-1965 to 4-26-1965, that (I) (we) last saw the deceased alive on 4-26-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE G.H. ASSEM - Pour Adib					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4-27-65	
23C. PHYSICIAN'S NAME (Type) G.H. ASSEM - Pour Adib					23D. ADDRESS Lutheran hospital of Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-29-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1965		25B. NAME OF REGISTRAR Robert E. Fackler			25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave Balto. Md. 29		

9-10-1848

10-10-1848

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24-10-1848

25-10-1848

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 4588

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Elsie V. Forster

2. DATE AND HOUR OF DEATH

4-27-65 5 17 M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Arbutus 21227 3300

D. STREET ADDRESS (If rural, give location)

1557 Lister Rd.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

M

8. DATE OF BIRTH

10-30-97

9. AGE (In years last birthday)

67

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SALESLADY housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

WASHINGTON, D. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Pierce Bell

14. MOTHER'S MAIDEN NAME

Caroline Simpson

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Frank Forster - Husband - Same

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.

CAUSE OF DEATH

(A) DUE TO

Carcinomatosis

(B) DUE TO

CA of Colon

(C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

8 mos -

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-16-65 to 4-27-65, that (I) (we) last saw the deceased alive on 4-27-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Miriam R. Cohen

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-27-65

23C. PHYSICIAN'S NAME (Type)

MIRIAM R. COHEN

M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4-30-65

24C. NAME OF CEMETERY or CREMATORY

Lorraine Pk. Cem.

24D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

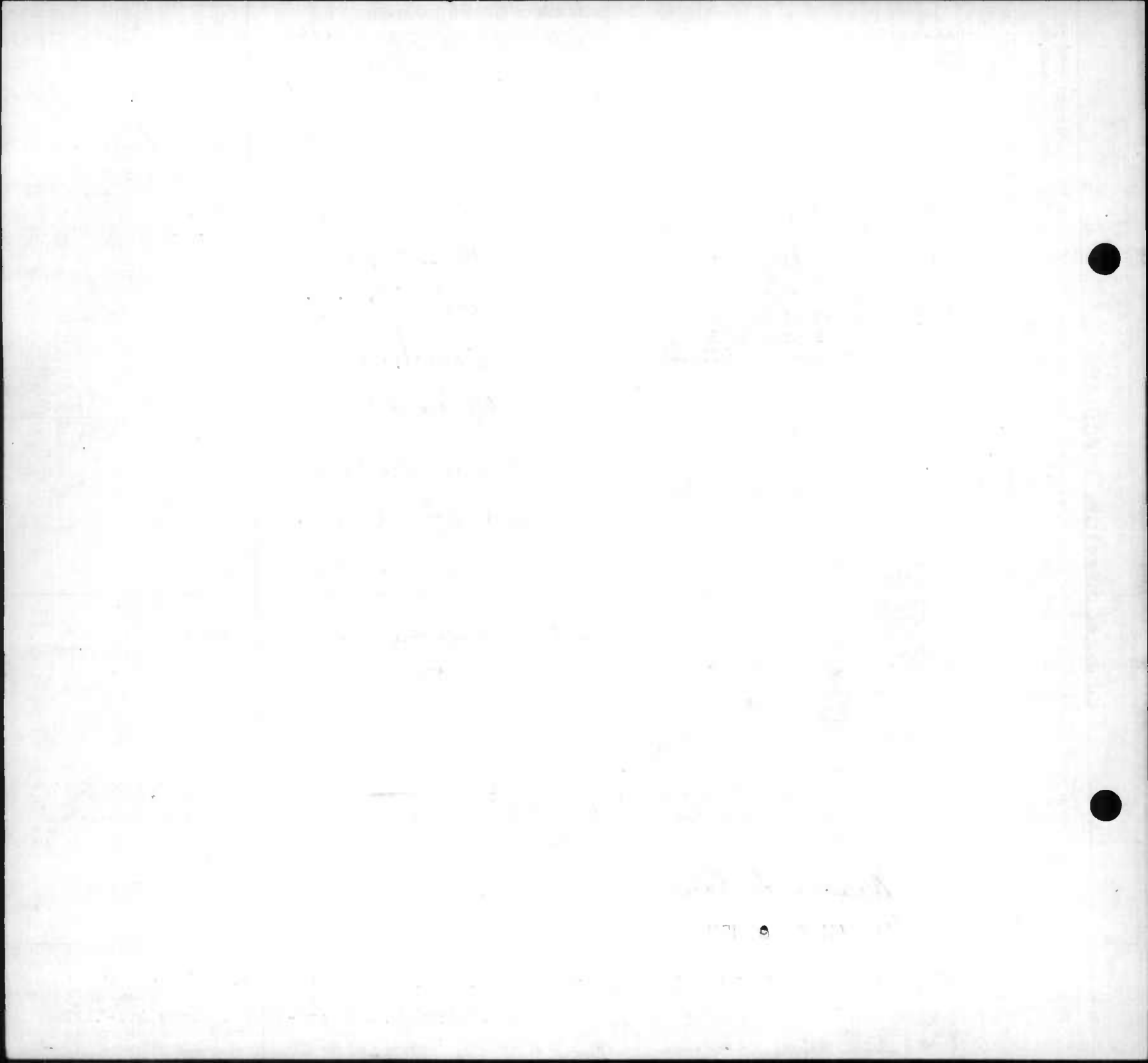
25A. DATE REC'D BY HEALTH DEPT.

APR 29 1965

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

Howard H. Hubbard-4107 Wilkens Ave-21229





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4589</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4589</span>		M.E. CASE NO. <span style="font-size: 1.2em;">65 4589</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Catherine Margaret Feick</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 27, 1965 8:30 P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">CHURCH HOME &amp; HOSPITAL</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">6-02</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2710 Orleans street</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Never married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9-2-88</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">76</span>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired salesgirl</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Gas &amp; Elec. Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">United States</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">William Feick</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Fisher</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212 05 3629</span>			17. INFORMANT <span style="font-size: 1.2em;">Theresa Novak (Friend)</span>		
18. ADDRESS <span style="font-size: 1.2em;">2712 Orleans St.</span>			19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Carcinoma of the Right Kidney months with intra-abdominal metastases</span>		
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			21. INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2 No</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-3-65</span> 19 to <span style="font-size: 1.2em;">4-27-65</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-27-65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">CESAR R. BARISO</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">4-27-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">CESAR R. BARISO</span>				23D. ADDRESS <span style="font-size: 1.2em;">Church Home &amp; Hospital - Balto. 31, Ind.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/29/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 28 1965</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span>			
25D. ADDRESS <span style="font-size: 1.2em;">3331 Brehms Lane #12</span>					

1993-94

5-636

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**FUNERAL DIRECTOR: IMPORTANT**

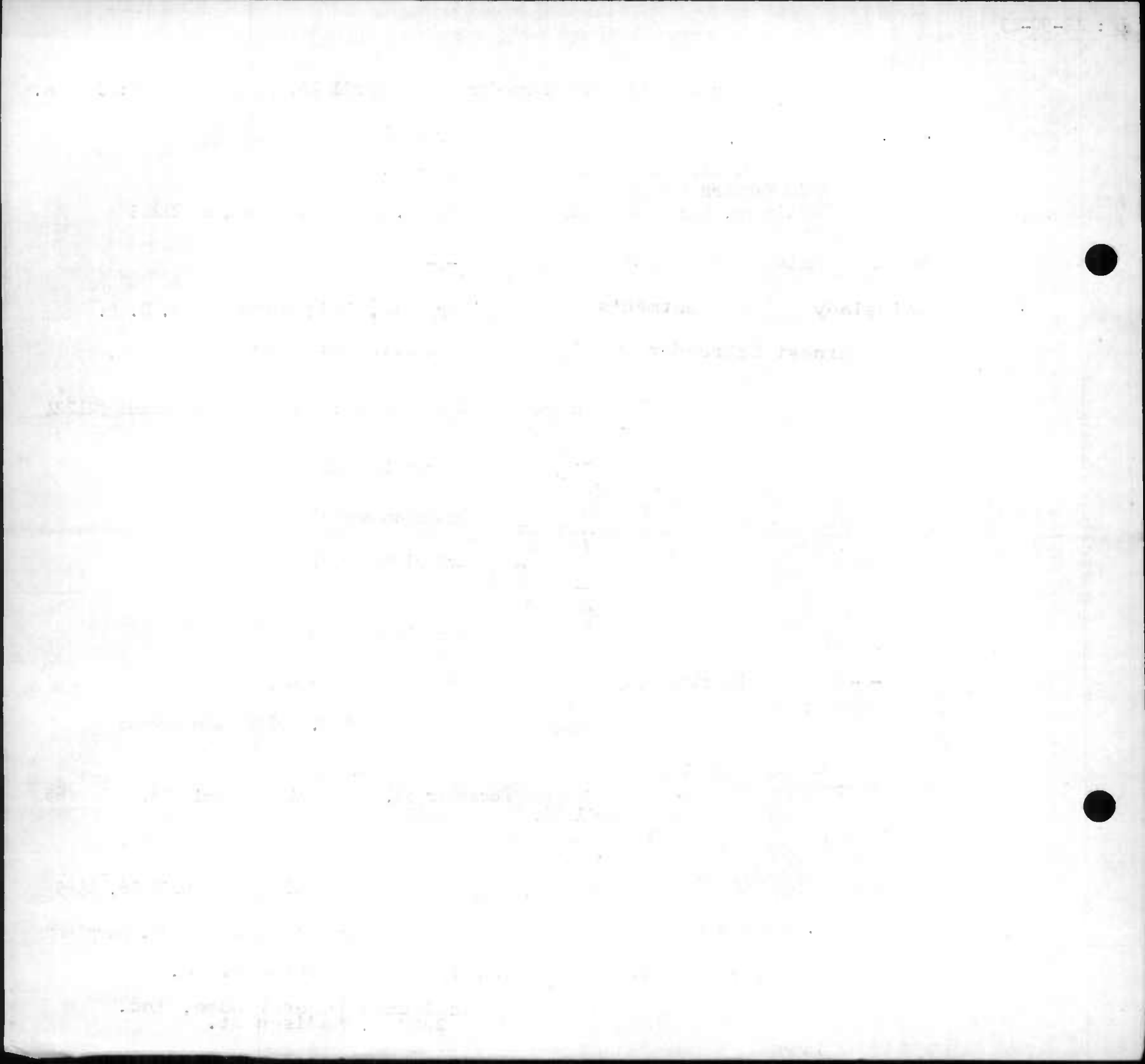
BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

65 4590

BIRTH NO. M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Marie Elizabeth Schroeder		April 26, 1965   2:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION  Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		Baltimore	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Female		White		Single	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
8-3-87		77		Saleslady	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland, Baltimore		U. S. A.		Ernest Schroeder	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
Julia Wernecke		(Yes, no or unknown) (If yes, give war or dates of service)		none	
17. INFORMANT ADDRESS		RECORDS: BCH: 4940 Eastern Avenue #21224		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	
				Myocardial Infarction	
				Bronchopneumonia	
				Arteriosclerosis	
				Decubitus Ulcers	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2-1-65		Fracture (L) Hip		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
		Home		1509 N. Collington Avenue	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
12 25 64 ?		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Unknown	
22. I certify that (I) (this hospital) attended the deceased from December 31, 1964 to April 26, 1965 that (I) (we) last saw the deceased alive on April 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. John Tomec				April 26, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. John Tomec				4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/29/65		Baltimore Cemetery	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore, Md.		Schimunek Funeral Home, Inc.		2601 E. Madison St.	



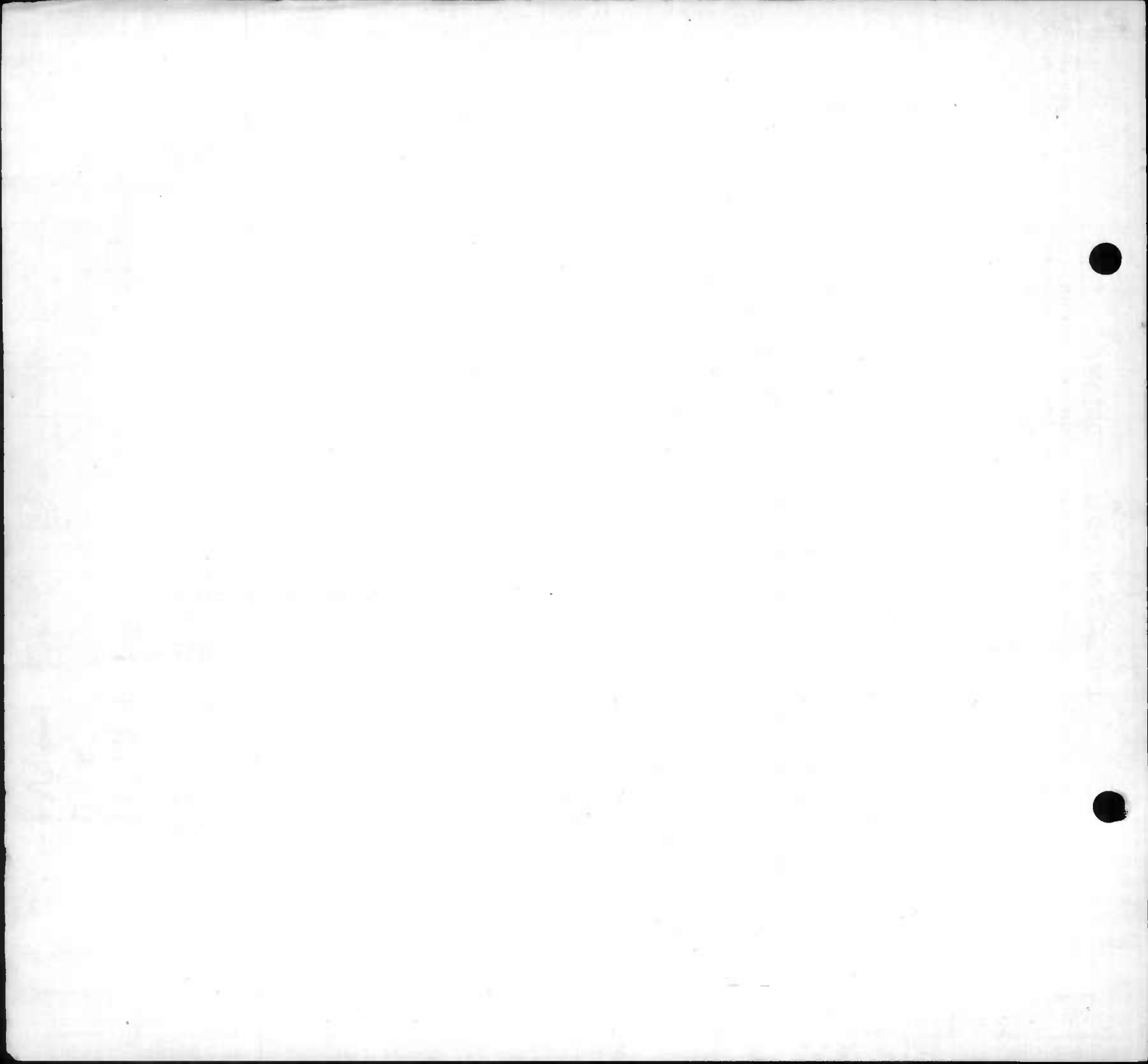
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 4591

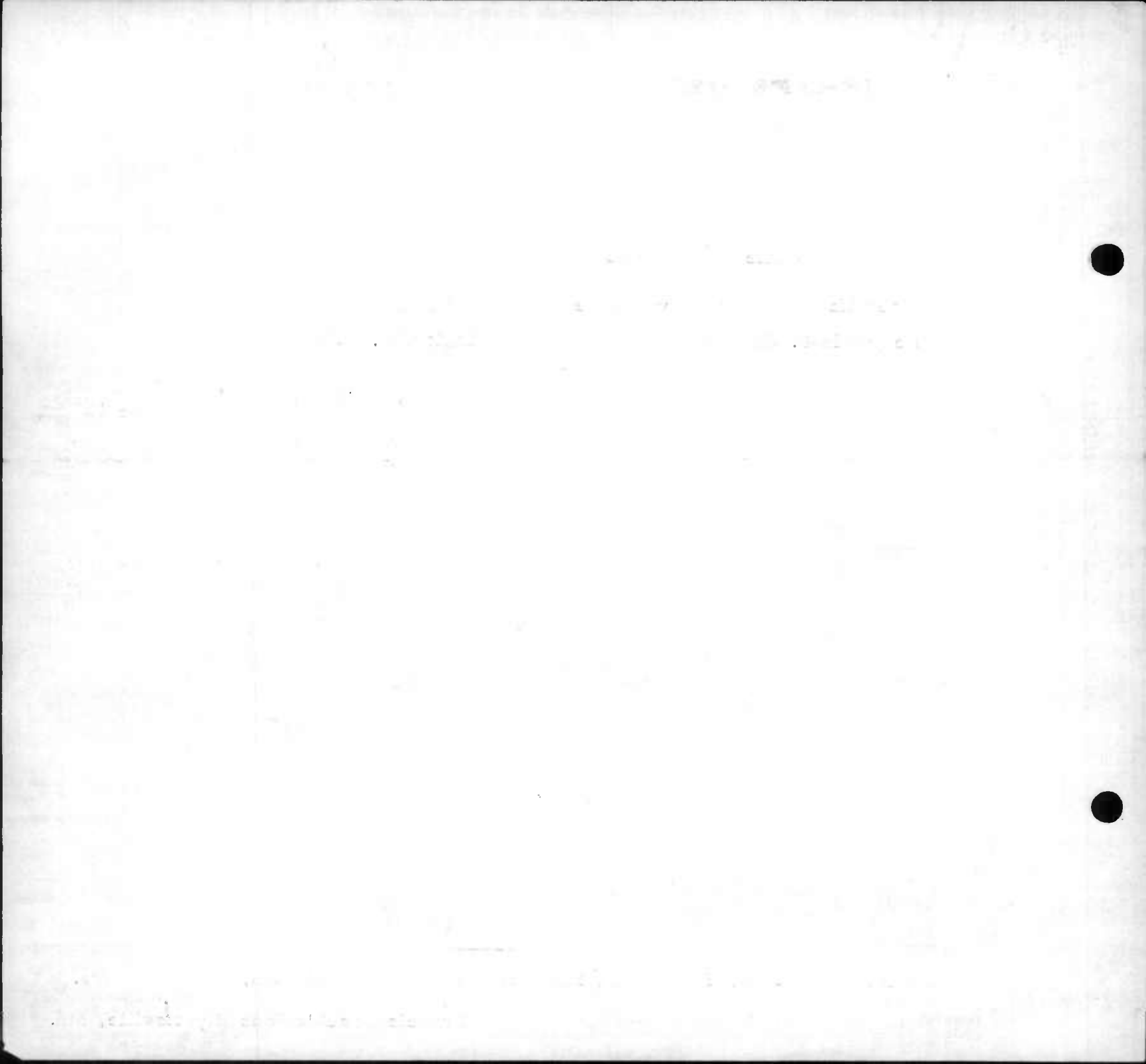
BIRTH NO. 65 4591		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) <b>HEATH, JOHN. FRANCIS.</b>		2. DATE AND HOUR OF DEATH <b>9.15 PM. 4.26.1965</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital) or institution, give street address or location) <b>UNION. MEMO, HOSP</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND.</b> B. COUNTY <b>27-13</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMOR.</b> D. STREET ADDRESS (If rural, give location) <b>5713. ROLAND, AVE.</b>	
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED.</b>	8. DATE OF BIRTH <b>9.29.94.</b>
9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <b>RHODE ISLAND.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN.</b>
13. FATHER'S NAME <b>HENRY. HEATH.</b>		14. MOTHER'S MAIDEN NAME <b>ANN. BRADSHAW.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>CHART.</b>
18. <b>545X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Massive Gastric hemorrhage due to gastric mucosal defects.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4.17.65 to 4.26.65</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Minimally fed and acute Nutritional anorexia &amp; vegetative</b>			
19A. DATE OF OPERATION <b>34.18.65</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>gastric bleeding</b>	20A. AUTOPSY? (Yes or No) <b>Yes.</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., on or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4.18.65</b> 19 to <b>4.26.65</b> 19, that (I) (we) last saw the deceased alive on <b>4.26.65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>a-a. Neshat</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>4.26.65</b>
23C. PHYSICIAN'S NAME (Type) <b>ANIR. ALI. NESHAT</b>		23D. ADDRESS <b>V. M. A.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-29-1965</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Thomas J. Kerry, Inc 1600 Hollins St.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4532					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4532				
1. NAME OF DECEASED (Type or Print) <b>BEATRICE PAYNE</b>					2. DATE AND HOUR OF DEATH <b>4/25/65 2:05pm</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Calvert</b>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>NORTH BEACH 3440</b>				
					D. STREET ADDRESS (If rural, give location) <b>215 BAY AVENUE</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11/18/21</b>	9. AGE (In years last birthday) <b>43 YR</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Benjamin F. Gordon</b>			14. MOTHER'S MAIDEN NAME <b>India Chadwell</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>RAYMOND PAYNE</b>		ADDRESS <b>SAME as #2</b>		
18. <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>					CAUSE OF DEATH <b>CA Ex Stage I-C-IV</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>Intestinal Obst</b> <b>4 days</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Sup Ventric Tachycardia</b>									
19A. DATE OF OPERATION <b>4/25/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal</b>		20A. AUTOPSY (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>NA</b>		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> <b>NA</b>		21F. HOW DID INJURY OCCUR? <b>NA</b>					
22. I certify that (I) (this hospital) attended the deceased from <b>4/13/65</b> 19 to <b>4/25/65</b> 19, that (I) (we) last saw the deceased alive on <b>4/25/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>[Signature]</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/25/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>[Signature]</b>					23D. ADDRESS <b>[Signature]</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/29/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arlington National</b>		24D. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>			

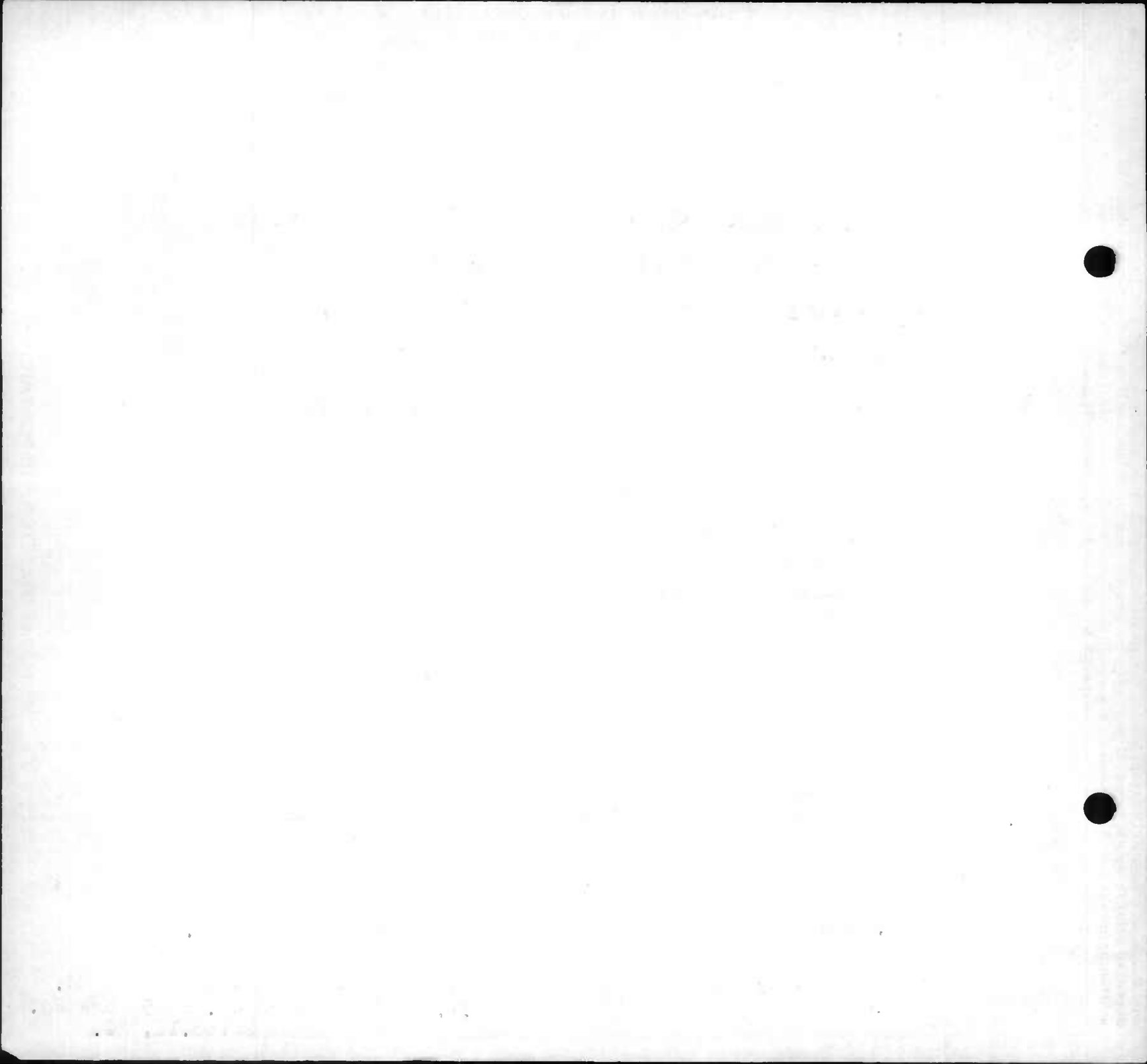




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

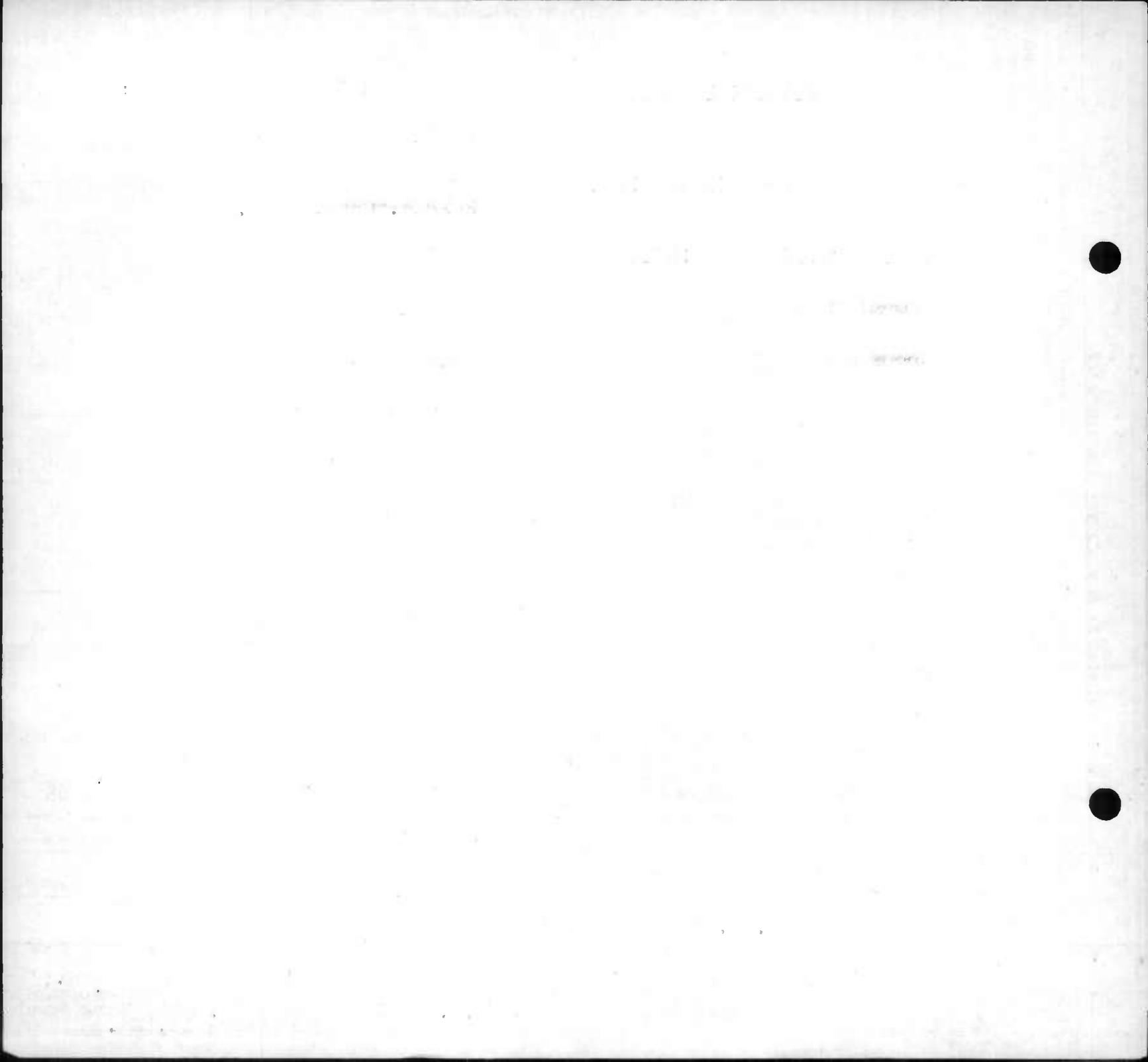
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4593</u>	
BIRTH NO. <u>65 4593</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Adeline A. Clark Ken.</u>		2. DATE AND HOUR OF DEATH <u>4-28-65</u> <u>8:35 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>21212</u>			
		D. STREET ADDRESS (If rural, give location) <u>312 E. Belvedere Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>8-4-89</u>	9. AGE (In years last birthday) <u>75</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>JAMES C. CLARKEN</u> ADDRESS <u>ROCKVILLE, Md. 1215 GLADSTONE DRIVE</u>	
18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>4-21</u> 19 <u>65</u> to <u>4-28</u> 19 <u>65</u> , that <del>we</del> (we) last saw the deceased alive on <u>4-28</u> 19 <u>65</u> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John Weagly</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-28-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. John Weagly</u>		23D. ADDRESS M.D. <u>South Baltimore General Hosp.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

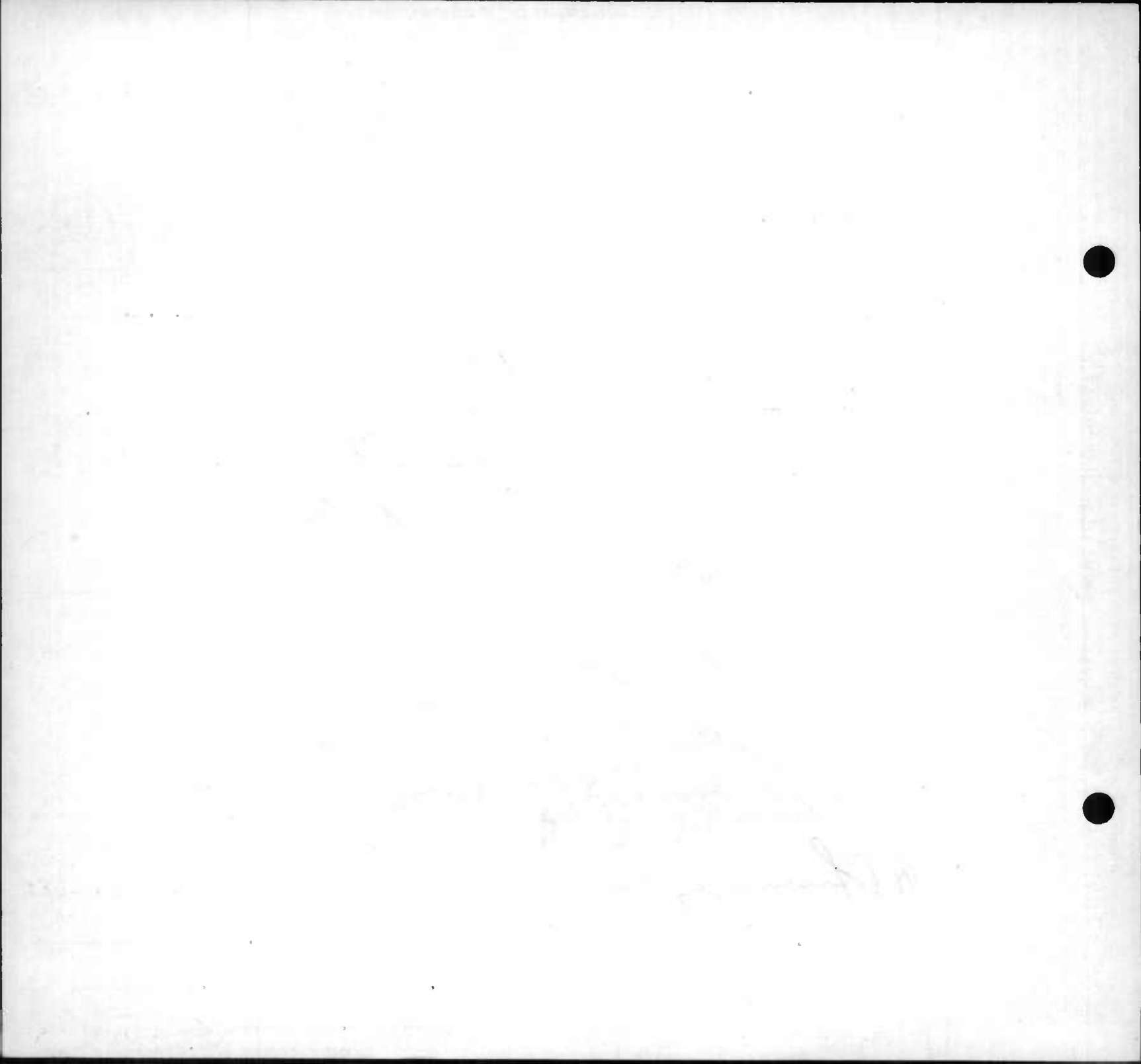
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4594</b>	
BIRTH NO. <b>65 4594</b>				M.E. CASE NO. <b>65 4594</b>	
1. NAME OF DECEASED (Type or Print) <b>F. BLANCHE LASSALLE</b>			2. DATE AND HOUR OF DEATH <b>4 28 65</b>   <b>1:30 P M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2212 N. CHARLES ST.</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>8 1 78</b>	9. AGE (In years lost birthday) <b>86</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CIVIL SERVICE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JEAN PIERPONT LASSALLE</b>			14. MOTHER'S MAIDEN NAME <b>HELENA CORLISS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>ST AGNES HOSP RECORDS</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.01</b> <b>Gen arterosclerosis</b> <b>ASPD &amp; CHF</b> <b>Senility</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4 27 19 65</b> to <b>4 28 19 65</b> , that (I) (we) last saw the deceased alive on <b>4 28 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. J. Rodriguez</b> M.D.				23B. DATE SIGNED <b>4-28-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. J. Rodriguez</b>				23D. ADDRESS <b>St Agnes Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/1/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		24E. (City, town, or county)		24F. (State) <b>Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 29 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Fickel</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>	
25D. ADDRESS <b>4905 York Road</b>		25E. (City, town, or county) <b>Baltimore</b>		25F. (State) <b>Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4595 CERTIFICATE OF DEATH					Registered No. 65 4595				
BIRTH NO. 65 4595					2. DATE AND HOUR OF DEATH April 28, 1965 7:20 P.M.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) Della H. Staines									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  1003 Renick Court Baltimore, Md. 21225					A. STATE Maryland				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 1003 Renick Court				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 6/7/99	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Keeler					14. MOTHER'S MAIDEN NAME Fannie Beal				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Franklin Staines 1003 Renick Ct.			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH Coronary Thrombosis Due to Pvt. aortic disease					INTERVAL BETWEEN ONSET AND DEATH 15 min 2				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1955 to 1945, that (I) (we) last saw the deceased alive on 4.26.1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Henry G. Summers, M.D.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED April 29, 1965	
23C. PHYSICIAN'S NAME (Type) Henry G. Summers					23D. ADDRESS 1101 Patapsco Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/65		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR William E. Johnson		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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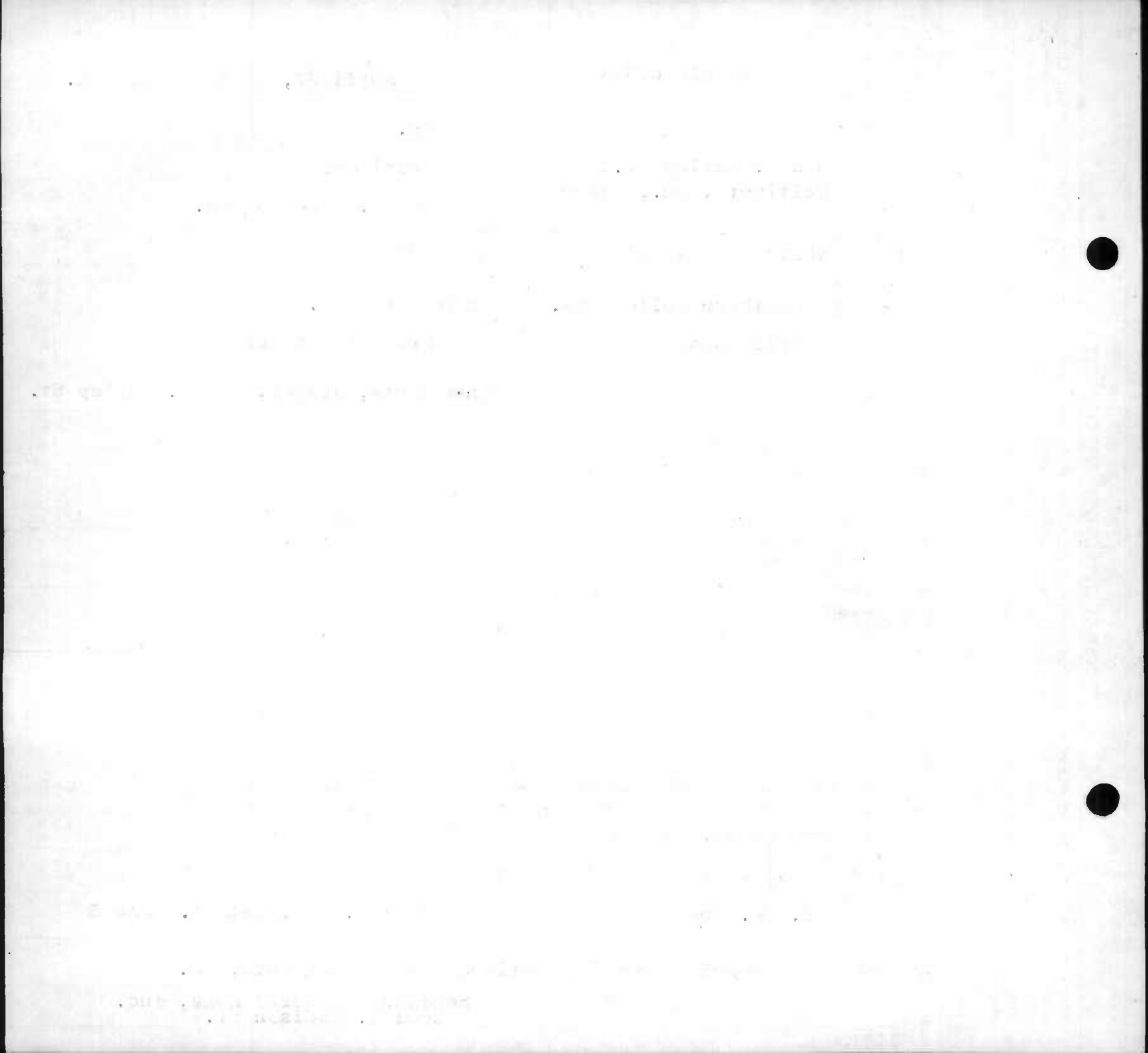
BIRTH NO. <span style="font-size: 1.5em;">65 4596</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 4596</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Martha Jeraldine Shiver</b>		2. DATE AND HOUR OF DEATH <b>April 26, 1965 1:25 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Idaho</b> B. COUNTY <b>Malad</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Malad</b> D. STREET ADDRESS (If rural, give location) <b>185 S. Main Street</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>sep.</b>	8. DATE OF BIRTH <b>7/19/34</b>	9. AGE (In years last birthday) <b>30</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ga.</b>	
13. FATHER'S NAME <b>George Caldwell</b>		14. MOTHER'S MAIDEN NAME <b>Udell Stripland</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, 11, Md</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
		(A) <b>Bilateral lobar pneumonia</b>			<b>Days</b>
		(B) <b>Inter-capillary glomerular sclerosis</b>			<b>Years</b>
		(C) <b>Diabetes</b>			<b>Years</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Jan. 26 19 65</b> to <b>Apr. 26 19 65</b> , that (2) (we) last saw the deceased alive on <b>Apr. 26 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>James H. Frank</i>				23B. DATE SIGNED <b>4/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>James H. Frank, Surgeon (R)</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/28/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>			
25B. NAME OF REGISTRAR <i>Robert E. Johnson</i>		25C. FUNERAL DIRECTOR <i>Elizabeth H. Johnson</i>			
25D. ADDRESS <b>8521 Loch Raven 4</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

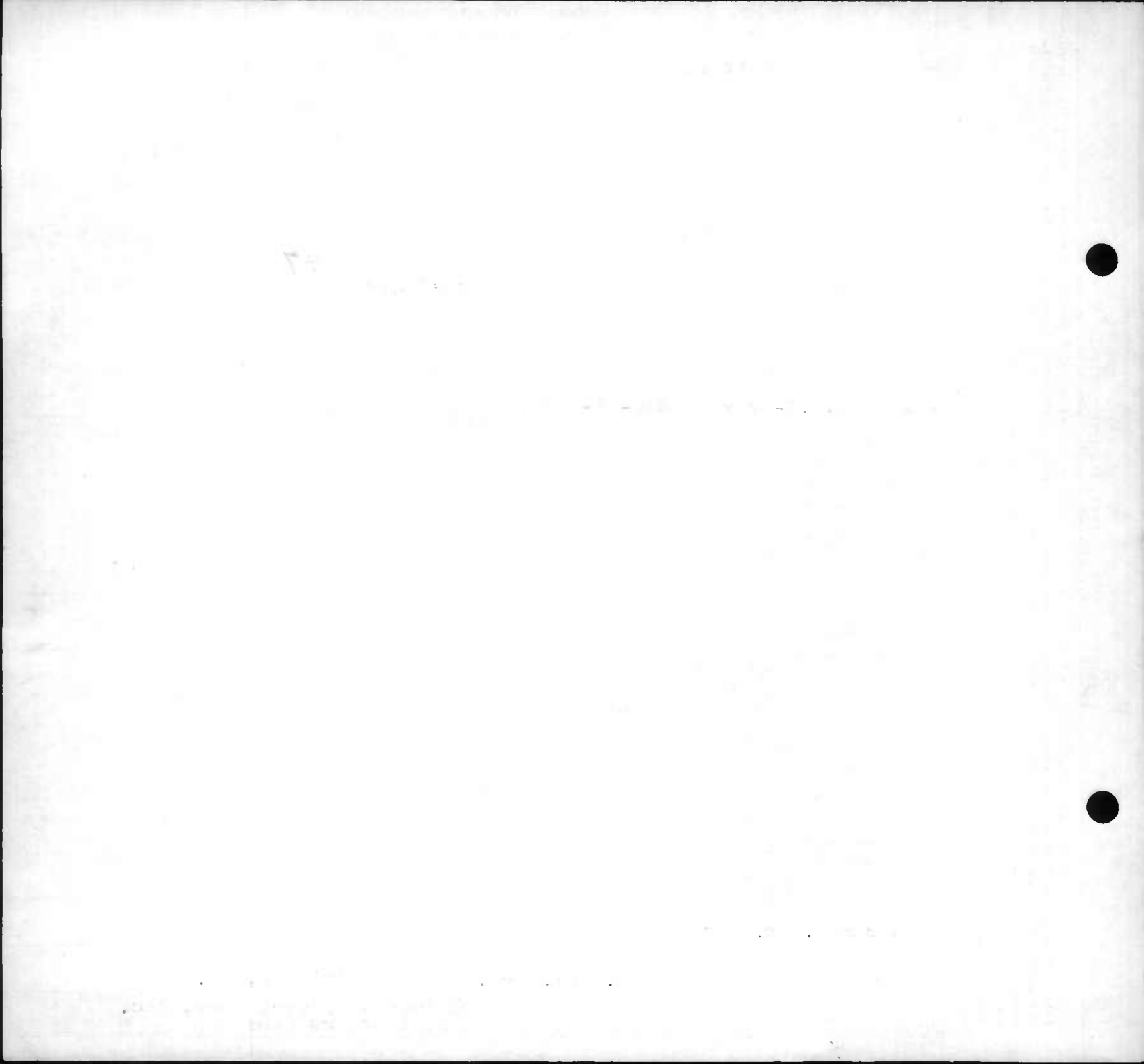
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>65 4597</b>	
BIRTH NO. <b>65 4597</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BESSIE LUNAK</b>		2. DATE AND HOUR OF DEATH <b>April 27, 1965 10:30 a. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>602 N. Curley St., Baltimore, Md., 21205</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY  C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>500 N. Kenwood Ave.</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>single</b>	8. DATE OF BIRTH <b>12/28/95</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Char-Lady Southern Police Sta.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Emil Lunak</b>				14. MOTHER'S MAIDEN NAME <b>Frances Barouch</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Anna Novak, sister, 602 N. Curley St.</b>			
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arterio Sclerosis unknown</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH <b>about 30 minutes</b>			
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4 - 25</b> <b>1965</b> to <b>4 - 27</b> <b>1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>4 - 26</b> <b>1965</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Wm. Dew</b>				23D. ADDRESS M.D. <b>2901 E. Monument St. Zone 5</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/30/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bohemian National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Farber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>2601 E. Madison St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
BIRTH NO.		65 4598		Registered No.				65 4598			
1. NAME OF DECEASED (Type or Print) <b>Patrick</b>				2. DATE AND HOUR OF DEATH <b>11:24 AM 4/29/65</b>							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2816 Mayfield Ave.</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>12-1-17</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Joseph Murphy</b>				14. MOTHER'S MAIDEN NAME <b>Christine Schultz</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W.2-Army</b>				16. SOCIAL SECURITY NO. <b>216-01-9440</b>		17. INFORMANT <b>Deceased prior to death.</b>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Liver Primary</b>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO				(B) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Diagnostic Laparotomy</b>		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/23/65</b> 19 <b>65</b> to <b>4/29/65</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>4/29</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.											
23A. SIGNATURE <b>Everard F. Cox</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>Everard F. Cox</b>				23D. ADDRESS M.D.							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>				25B. NAME OF REGISTRAR <b>E. Fairley</b>		25C. FUNERAL DIRECTOR <b>Schmunek Funeral Home, Inc.</b>				ADDRESS <b>3331 Brehms Lane</b>	



BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH RAYMOND SHARP

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965 3:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3514 Elmora Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

11/2/12

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Steel Foreman - Broker Mfg. Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Philadelphia, Pa.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Sharp

14. MOTHER'S MAIDEN NAME

Christine Mapestz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215-18-0838

17. INFORMANT 3514 Elmora Ave., Zone 132

Sarah Welsh Sharp, wife,

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Craniocerebral Injury.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Plant

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Brocker Steel Co., Ostend &amp; Ridgely Sts.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

4 28 '65 P

21E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Struck by load of steel being lifted by  
crane.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/1/65

23C. NAME of CEMETERY or CREMATORY

Moreland Mem. Park

23D. LOCATION

(City, town, or county)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

ADDRESS

RECEIVED

11/2/12

RECEIVED

Baltimore, Md.

Special Agent in Charge, U.S. Bureau of Investigation

John Edgar Hoover

Director, Federal Bureau of Investigation

3311 E. 11th Ave., Baltimore, Md.

312-11-0412 (Bureau of Investigation)

Baltimore, Md.

Washington, D.C.

11/2/12

RECEIVED

3311 E. 11th Ave., Baltimore, Md.  
Baltimore, Md.

C-623

65 4600

BALTIMORE CITY HEALTH DEPARTMENT

65 4600

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

YEN CHRISTIAN CHRISTENSEN

2. DATE AND HOUR PRONOUNCED DEAD

April 26, 1965

10:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6902 Ridgeway Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

2/6/95

9. AGE (In years  
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

COAST GUARD

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

DENMARK

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

U.S. COAST GUARD 28-14-6376

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Friend ADDRESS

JENNIE BIEHL-6902 RIDGEWAY RD

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-27-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/3/65

23C. NAME of CEMETERY or CREMATORY

Balto. Nat. Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane



OFFICE OF THE ATTORNEY GENERAL

*[Handwritten signature]*

Printed and Published by the  
State of Maryland, 1931  
Baltimore, Md.  
State of Maryland, 1931  
Baltimore, Md.



BIRTH NO. 65 4601

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LOUIS SMITZEL (Schmeitzl)

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1965 3:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5000 Ardmore Way

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan 8 1894

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Pipe fitter ret

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FULL NAME

Louis J Ssmitzel

14. MOTHER'S MAIDEN NAME

Anna N Conrad

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

yes

WWI

16. SOCIAL  
SECURITY NO.  
213-05-8107

17. INFORMANT

ADDRESS

Mrs Minnie Smitzel 5000 Ardmore Way

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-28-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

April 30/65

23C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert E. Talbot

24C. FUNERAL DIRECTOR

ADDRESS

Ulrich Funeral Home 4210 Belair Road

WALLINGTON

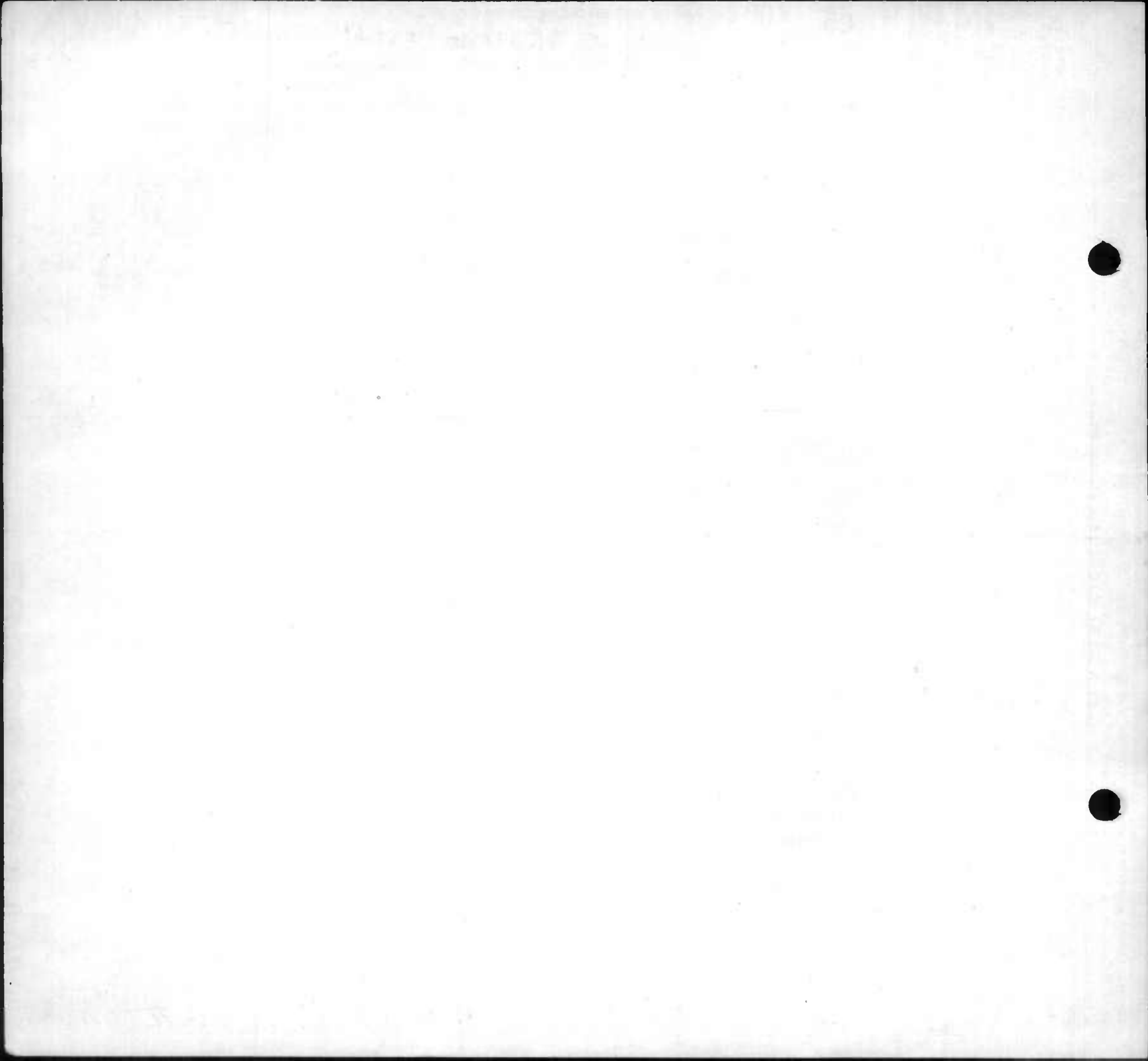
PAID CENTRAL

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

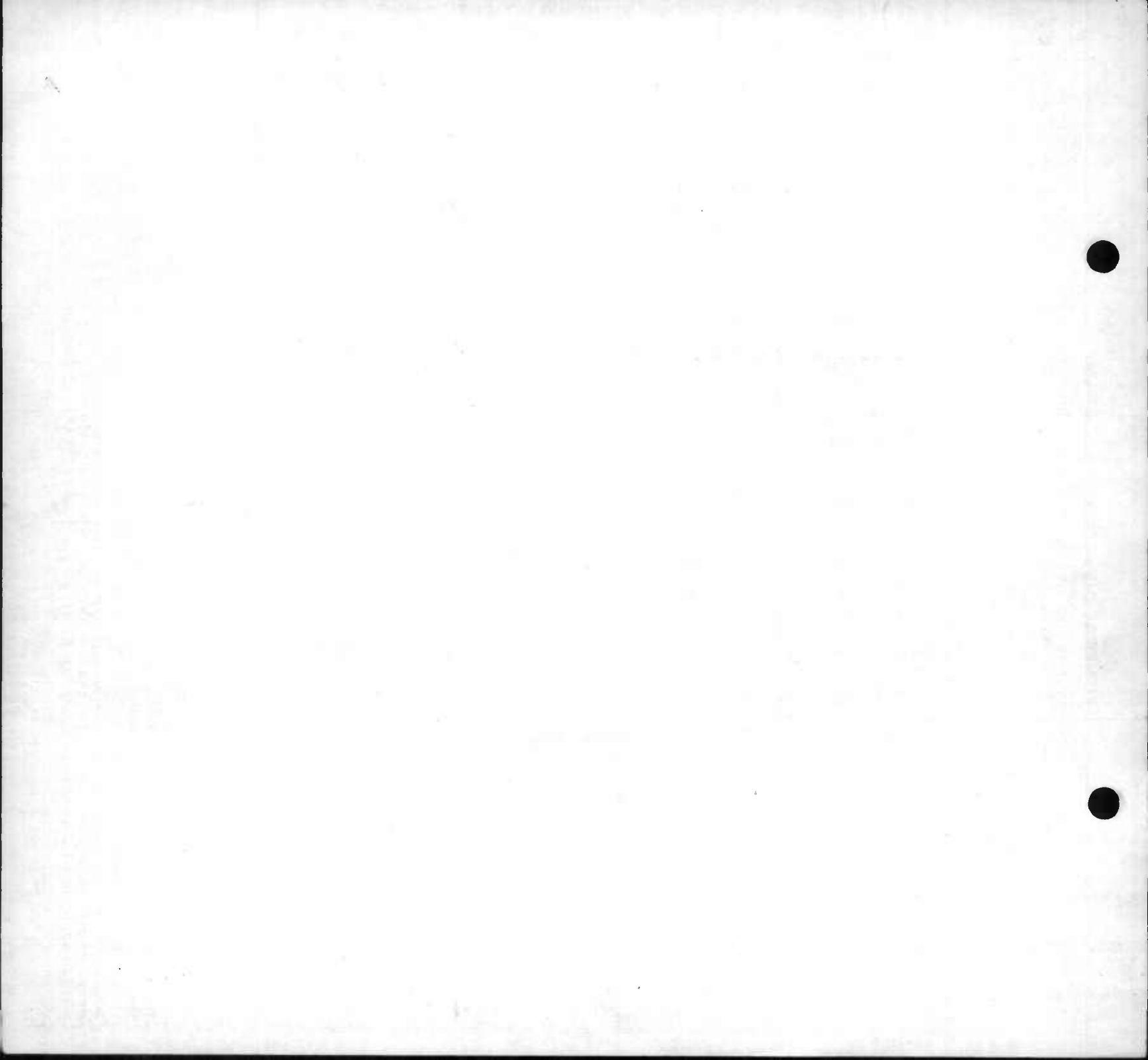
BIRTH NO. <span style="float: right;">65 4602</span>				CERTIFICATE OF DEATH		Registered No. <span style="float: right;">65 4602</span>		
1. NAME OF DECEASED (Type or Print) <u>Thomas Ernst Rohrman</u>				2. DATE AND HOUR OF DEATH <u>4-28-65</u> <u>11:00 AM</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital - Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Forest Hill</u> D. STREET ADDRESS (If rural, give location) <u>Boggs Road</u> <u>Forest Hill, Harford Co.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>		8. DATE OF BIRTH <u>4-28-65</u>	9. AGE (In years last birthday) <u>5</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> <u>MARYLAND</u>		
13. FATHER'S NAME <u>CHARLES A. Rohrman</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Hornig</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Charles A. Rohrman</u> ADDRESS <u>Forest Hill, Maryland</u> <u>FATHER</u>		
18. <u>289.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>operated 4/25/65 - double bowel resection</u> <u>operated 4/28/65 - distal ileum resection</u>				CAUSE OF DEATH (A) <u>MECONIUM ILEUS</u> DUE TO (B) <u>PERITONITIS</u> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <u>1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>4-25-65</u> 19 <u>65</u> to <u>4-28</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4-28</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>Green</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-28-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>EC CRUZ</u>				23D. ADDRESS M.D. <u>SINAI HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/29/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Rock Spring</u>		24D. LOCATION (City, town, or county) (State) <u>Forest Hill, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles O. Kurtz Jarrettsville, Md</u>				



FUNERAL DIRECTOR: IMPORTANT

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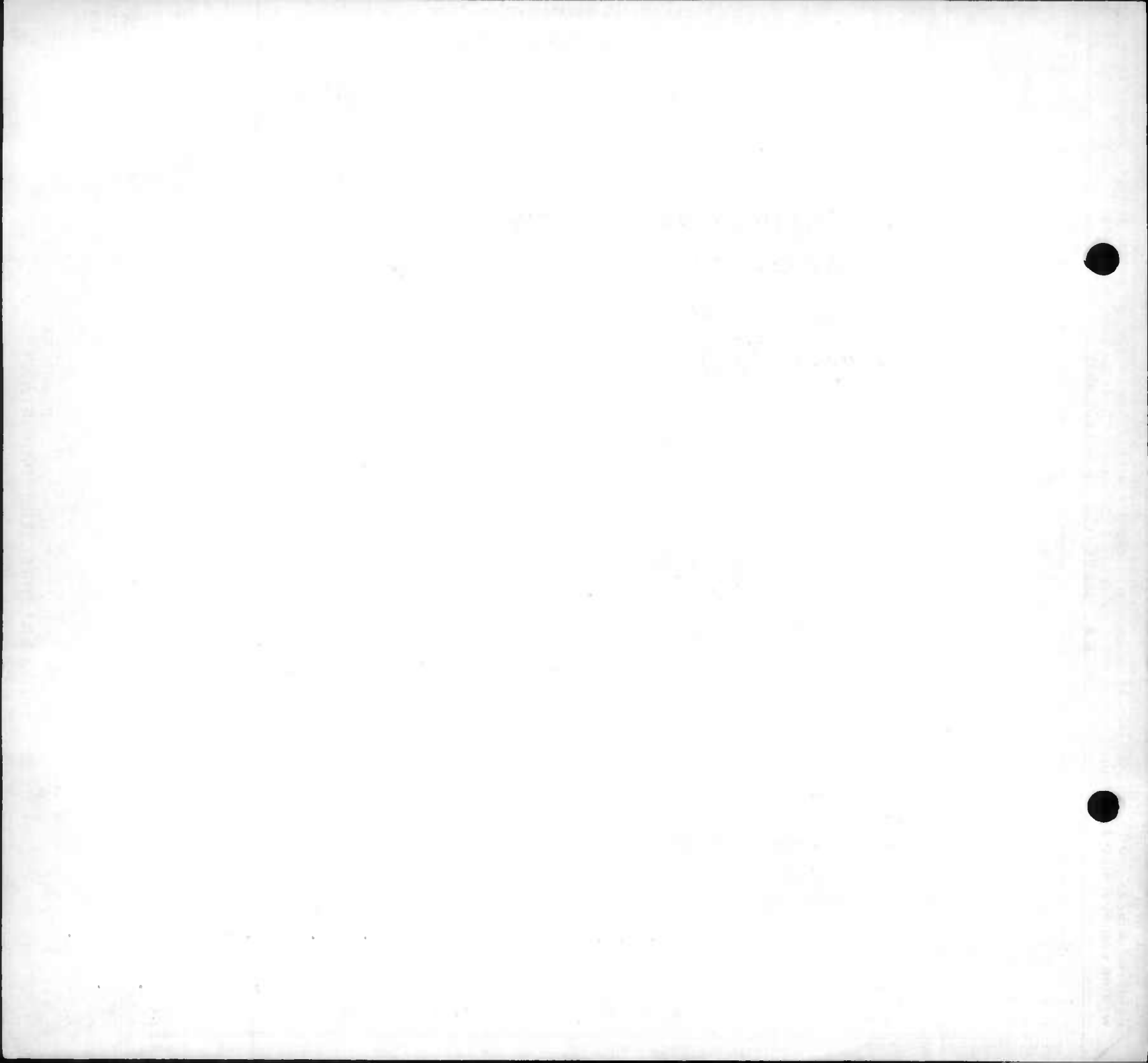
BIRTH NO. 65 4603		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 4603	
1. NAME OF DECEASED (Type or Print) <b>FANNY BEALE STEVENSON</b>			2. DATE AND HOUR OF DEATH <b>4.28.65</b>   1 <sup>15</sup> <b>A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hospital FOR THE WOMEN OF MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1533 BOLTON ST.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>12-4-1873</b>	9. AGE (In years last birthday) <b>92</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY STEVENSON</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>213-48-7070</b>		17. INFORMANT <b>CHART</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD with Congestive Heart Failure.</b>			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) DUE TO <b>Intestinal Obstruction</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-23</b> 19 <b>65</b> to <b>4-28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dradema B. Simon, M.D.</b>			23B. DATE SIGNED <b>4-28-65</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial 4/30/65</b>		<b>4/30/65</b>		<b>Green Mt.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>		25B. NAME OF REGISTRAR <b>E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Stewart M. Simon</b>	
				ADDRESS <b>1084 North Baltimore</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4604</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4604</span>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Eleanor J. Castro</i>		2. DATE AND HOUR OF DEATH <i>4-28-65 9:30 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>24-04</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hosp</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21230</i>			
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>1510 BELT ST.</i>			
5. SEX <i>F.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>1892 9-22-65</i>	9. AGE (In years last birthday) <i>72</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>
13. FATHER'S NAME <i>Angel Tosi</i>			14. MOTHER'S MAIDEN NAME <i>Mary Calzetta</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Family Same</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i>		CAUSE OF DEATH (A) DUE TO <i>ASCVD</i> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <i>4-22</i> 19 <i>65</i> to <i>4-28</i> 19 <i>65</i> ; that <del>the</del> (we) last saw the deceased alive on <i>4-28</i> 19 <i>65</i> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kermit Bonovich</i>				23B. DATE SIGNED <i>4-28-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>KERMIT BONOVICH, M.D.</i>		23D. ADDRESS <i>South Balto. Gen. Hosp. - 1213 Light St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5 1 65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Elkridge, Howard Co. Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 30 1965</i>		25B. NAME OF REGISTRAR <i>Mc Cully</i>	
25C. FUNERAL DIRECTOR ADDRESS <i>130 E Fort Ave</i>					





BIRTH NO.

65 4605

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

IGNATIUS J. GIBSON

2. DATE AND HOUR PRONOUNCED DEAD

4-25-65

8:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. JOSEPH'S HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3245 Belair Road 21213

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

2-15-1918

9. AGE (In years  
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

STOCK CLERK

10B. KIND OF BUSINESS OR INDUSTRY

CROSS TOWN  
LIQUOR CO

11. BIRTHPLACE (State or foreign country)

BALTO., MD.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JOHN P. GIBSON

14. MOTHER'S MAIDEN NAME

MARY A. GIBSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

YES

W.W.II ARMY

16. SOCIAL  
SECURITY NO.

218-10-2437

17. INFORMANT

BROTHER

ADDRESS Todd

MR. GERARD GIBSON 5511 TODD AVE 6

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) Bronchopneumonia

Complicating craniocerebral injury with  
skull fracture and extradural hematoma

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?Found: Lying in hallway at  
3245 Belair Road (2nd floor)21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 22 '65 ?

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fell and struck head

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-26-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-30-1965

23C. NAME OF CEMETERY

CATHEDRAL

23D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert F. Taylor

24C. FUNERAL DIRECTOR

John Walter Berlin 5444 Belair Rd.

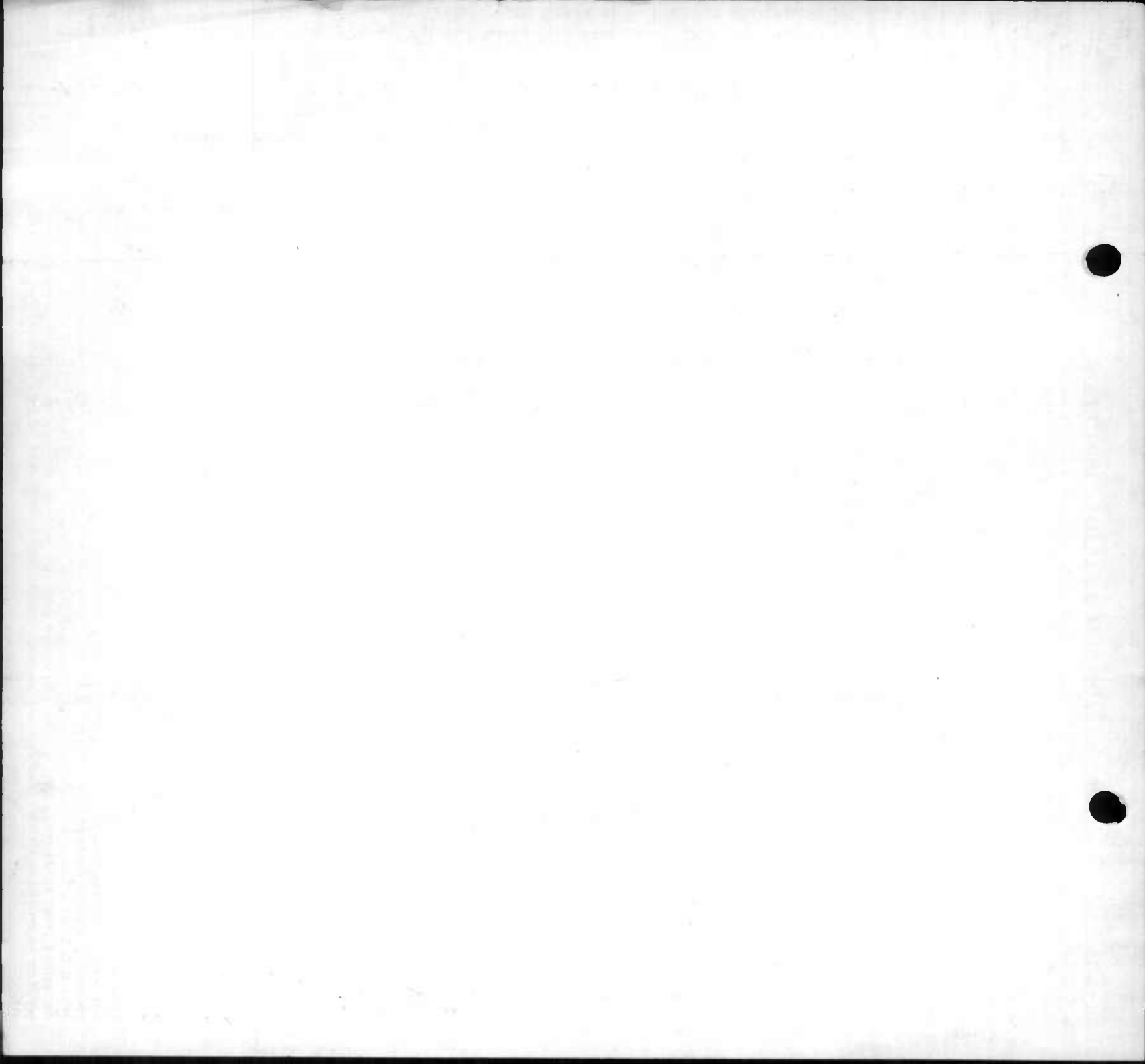
ADDRESS



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4606</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4606</span>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WILLIAM W. ROBERSON</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4-27-65 12:05 P.M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">FAYETTE CONVALESCENT HOME</span>				A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE 5370</span>			
D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">27 BROADSHIP RD.</span>							
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">9-28-1890</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">74</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">CLERK</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">STEEL</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VIRGINIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">THOMAS G. ROBERSON</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">JANE KATHRYN BROWN</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-07-4556</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">JOSEPHINE G. ROBERSON, SAME AS #4</span>			
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <span style="font-size: 1.2em;">II</span>				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">CORDNARY THROMBOSIS</span> DUE TO <span style="font-size: 1.2em;">ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</span> (B) <span style="font-size: 1.2em;">VASCULAR DISEASE</span> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 DAYS</span>  <span style="font-size: 1.2em;">10 YRS</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">JUNE 11</span> 19 <span style="font-size: 1.2em;">56</span> to <span style="font-size: 1.2em;">APRIL 27</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">APRIL 27</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Paul G. Herold</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4-27-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">PAUL G. HEROLD</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">10 W. MADISON ST.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/30/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Moreland Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 30 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jolley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Walter Brooks Bradley, Inc.</span>		ADDRESS <span style="font-size: 1.2em;">Dundalk 22</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>65-5762</span> <span>65 4607</span> </div> <div style="display: flex; justify-content: space-between;"> <span>65 4607</span> <span>Registered No. 65 4607</span> </div>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>	
BIRTH NO. <span style="float: right;">65 4607</span> M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="float: right;">ROBERT JOSEPH AUFFARTH</span>	
2. DATE AND HOUR OF DEATH <span style="float: right;">4-27-65 4:50 P M.</span>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="float: right;">UNIVERSITY HOSPITAL</span>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">BALT</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">BALTIMORE 5300</span>	
D. STREET ADDRESS (If rural, give location) <span style="float: right;">366 LANLEY RD. Edgewater Gts.</span>		5. SEX <span style="float: right;">M</span> 6. RACE <span style="float: right;">W</span> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="float: right;">—</span>	
8. DATE OF BIRTH <span style="float: right;">3-11-65</span> 9. AGE (In years last birthday) <span style="float: right;">1 mo</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">—</span> 10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">—</span>	
11. BIRTHPLACE (State or foreign country) <span style="float: right;">MARYLAND</span> 12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">USA</span>		13. FATHER'S NAME <span style="float: right;">FREDERICK AUFFARTH</span> 14. MOTHER'S MAIDEN NAME <span style="float: right;">LOUISE SCRIPTURE</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="float: right;">—</span> 16. SOCIAL SECURITY NO. <span style="float: right;">—</span>		17. INFORMANT <span style="float: right;">FATHER</span> ADDRESS <span style="float: right;">—</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <span style="float: right;">BRONCHOPNEUMONIA</span> DUE TO (B) <span style="float: right;">CARDIAC FAILURE</span> DUE TO (C) <span style="float: right;">INTERVENTRICULAR SEPTAL DEFECT</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="float: right;">754.21</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="float: right;">PULMONARY ARTERY BANDING</span>		19A. DATE OF OPERATION <span style="float: right;">4-19-65</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="float: right;">IVSD</span>	
20A. AUTOPSY? (Yes or No) <span style="float: right;">N/O</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="float: right;">—</span>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="float: right;">—</span>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="float: right;">—</span>		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="float: right;">—</span> 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <span style="float: right;">—</span>		22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">4-12 1965</span> to <span style="float: right;">4-27 1965</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">4-27 1965</span> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="float: right;">N. W. Todd</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="float: right;">4-27-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">NEVINS W. TODD</span> M.D. 23D. ADDRESS <span style="float: right;">UNIVERSITY HOSPITAL</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span> 24B. DATE <span style="float: right;">4/30/65</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Bel Air Memorial</span> 24D. LOCATION (City, town, or county) (State) <span style="float: right;">Bel Air, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">APR 30 1965</span> 25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Fairley, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="float: right;">Connolly</span> ADDRESS <span style="float: right;">300 Mace Ave. 21</span>		25D. <span style="float: right;">—</span>	

4 3 1000  
4 3 1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4608		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4608	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Ethel Craig			April 28, 1965 1:10 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Anderson Nursing Home			A. STATE Maryland B. COUNTY 27-12		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 9 W. Melrose Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH Oct. 26, 1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Dr, Thomas Craig			14. MOTHER'S MAIDEN NAME Louise Alvord		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Miss Eleanor Mussellman		ADDRESS 9 W. Melrose Ave
18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Atherosclerotic cardio-renal disease (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH 7 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 26, 1938 to April 28, 1965, that (I) (we) last saw the deceased alive on April 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. Joema Boyd				23B. DATE SIGNED April 30, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 24 E. Eager St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/65		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION Baltimore		24E. LOCATION Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR John O. Mitchell & Sons, 1900 Eutaw Place, Baltimore 17	





M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) THERESA HASKIN  
2. DATE AND HOUR PRONOUNCED DEAD April 26, 1965 9:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
FRANKLIN SQUARE HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 19-01

D. STREET ADDRESS (If rural, give location)  
403 N. Mount Street

5. SEX Female 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)  
8. DATE OF BIRTH Nov. 26 1964 9. AGE (In years last birthday) 5 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Balt. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Haskin 14. MOTHER'S MAIDEN NAME Carrie-Haskin-Thompson-403 N. Mount St.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia DUE TO

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congenital heart disease DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

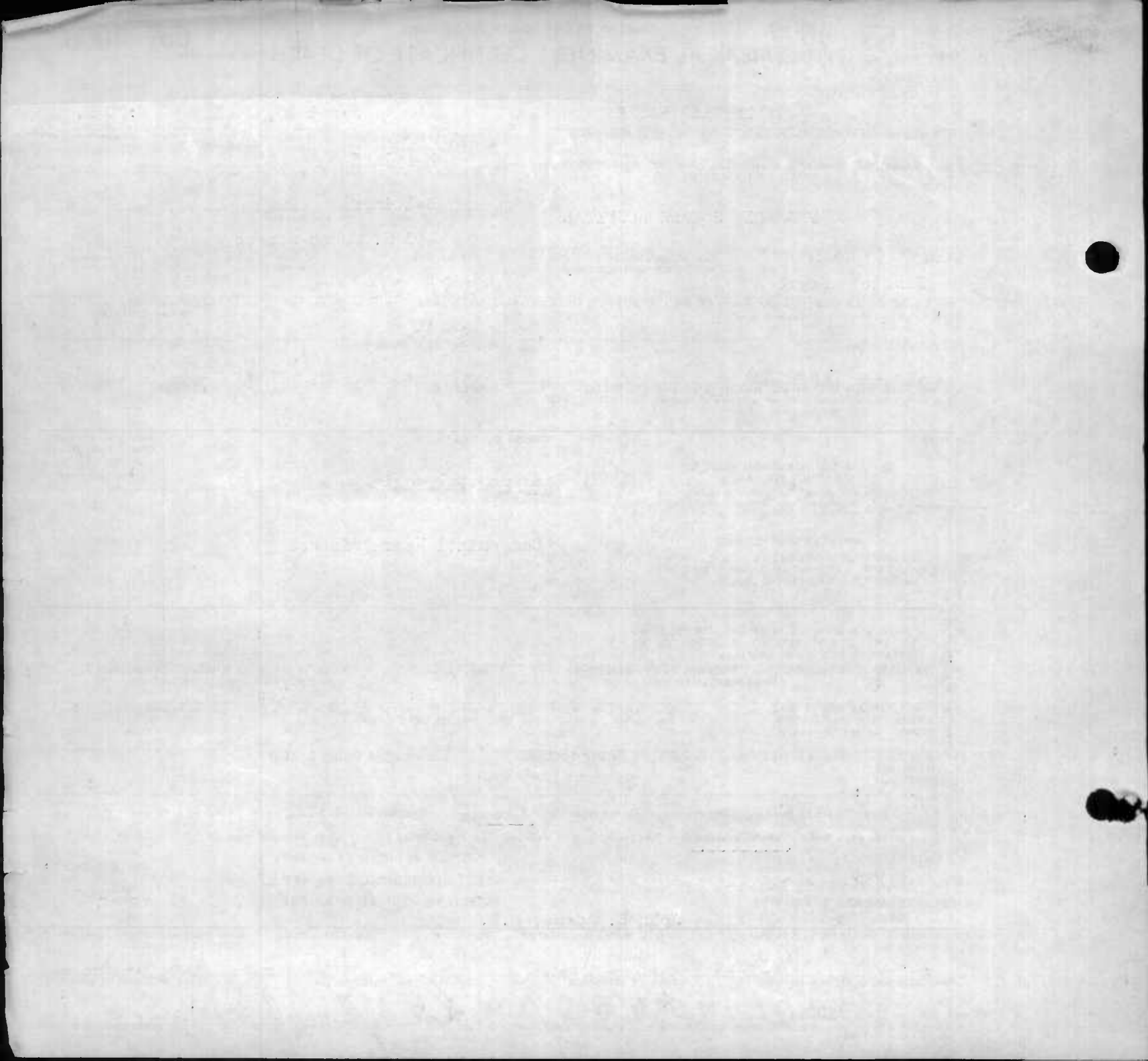
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner  
ACTUAL SIGNATURE John E. Adams, M.D. CHIEF MEDICAL EXAMINER  
EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER  
ASSOCIATE MEDICAL EXAMINER

DATE SIGNED  
4-27-65

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 4/30/65 23C. NAME of CEMETERY or CREMATORY Mt. Calvary 23D. LOCATION (City, town, or county) (State) Chesapeake - Maryland

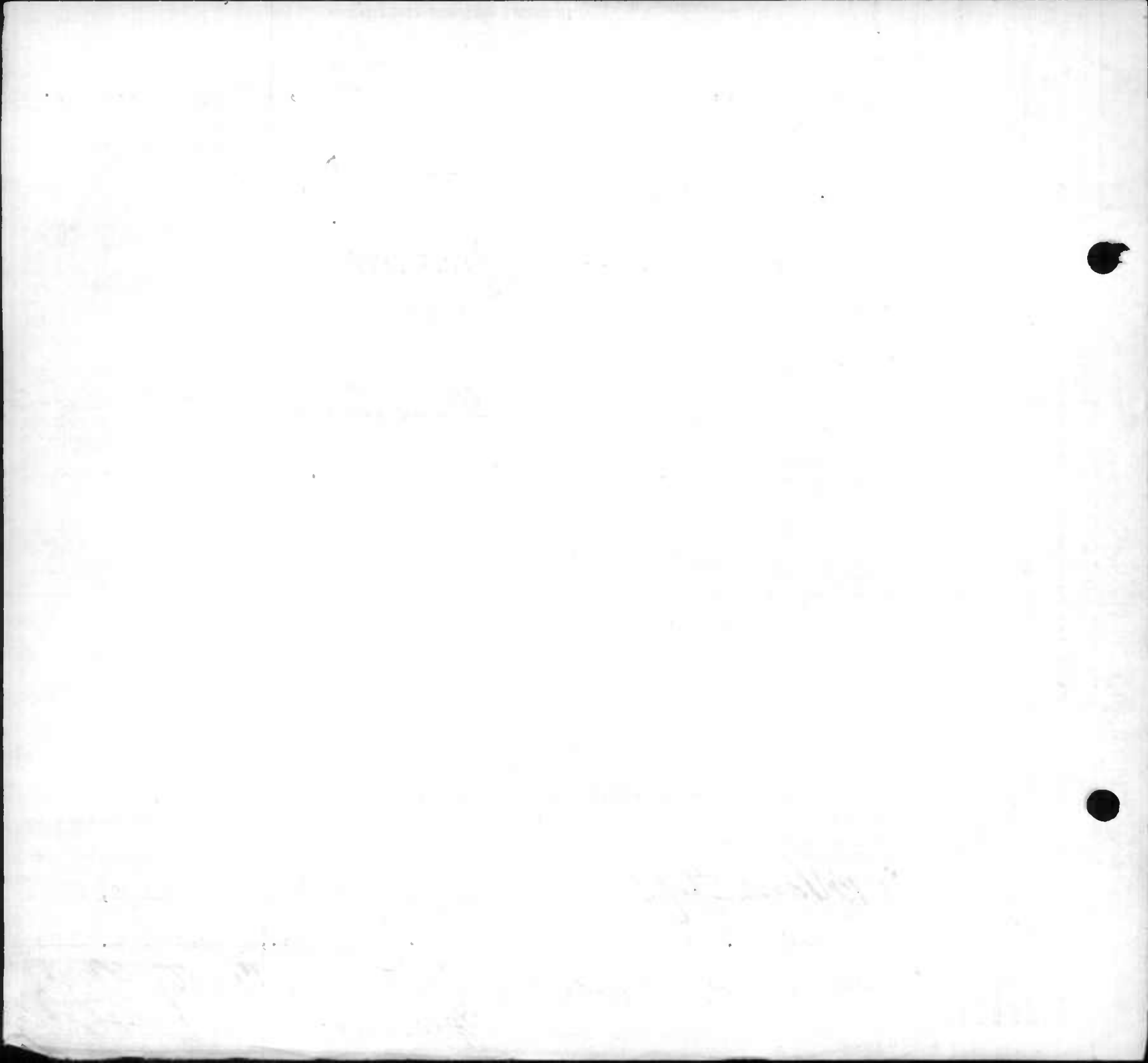
24A. DATE REC'D BY HEALTH DEPT. APR 30 1965 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR 24D. ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4610</u>	
BIRTH NO. <u>65 4610</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Bagley, Cephus</u>		April 28, 1965   2:45 p. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>9-08</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Jan. 2, 1897</u>		9. AGE (In years last birthday) <u>68</u>		10. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Grace Tucker 1702 Madison St</u>	
18. <u>332X I</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <u>Infarct of left pons.</u>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) <u></u>			
ANTECEDENT CAUSES		(C) <u></u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Yes</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 27,</u> 19 <u>65</u> to <u>April 28,</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>April 28,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William B. VandeGrift</u>				23B. DATE SIGNED <u>April 29, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>William B. VandeGrift</u>				23D. ADDRESS <u>1400 N. Caroline St., Baltimore, Md. 21213</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 3/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>My Calvary Cemetery A. A. County Md.</u>	
24D. LOCATION (City, town, or county) (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Tucker, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Frank E. Erickson</u>		25D. ADDRESS <u>129 N. Calhoun</u>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAGGIE

CLARK

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965

1:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1325 N. Patterson Park Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

May 29, 1887

9. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dorothy Catw/1325 Patterson Park Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic  
~~XXXXX~~ Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

State

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

WALTER  
F. COOPER

WALTER F. COOPER  
JAN 10 1900

WALTER F. COOPER  
JAN 10 1900

WALTER F. COOPER  
JAN 10 1900

WALTER F. COOPER  
JAN 10 1900



1  
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65 4612

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 4612

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROBERT L. COBB

2. DATE AND HOUR PRONOUNCED DEAD

April 29, 1965 9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3906 Cottage Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

April 28, 1938

9. AGE (In years  
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

BIRTHPLACE (State or foreign country)

N. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank Cobb

14. MOTHER'S MARDEN NAME

Callie Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown, if yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Frank Cobb 3906 Cottage Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)

(A) Sick Cell Anemia.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 3/65

23C. NAME of CEMETERY or CREMATORY

Gr. Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

A.A. County Ind

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert G. Salsbery

24C. FUNERAL DIRECTOR

Frank F. Ellickson 11297 N. Caroline

ADDRESS

THE DOCUMENT

1-1-1

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Handwritten text, possibly a signature or date.

Handwritten text, possibly a signature or date.

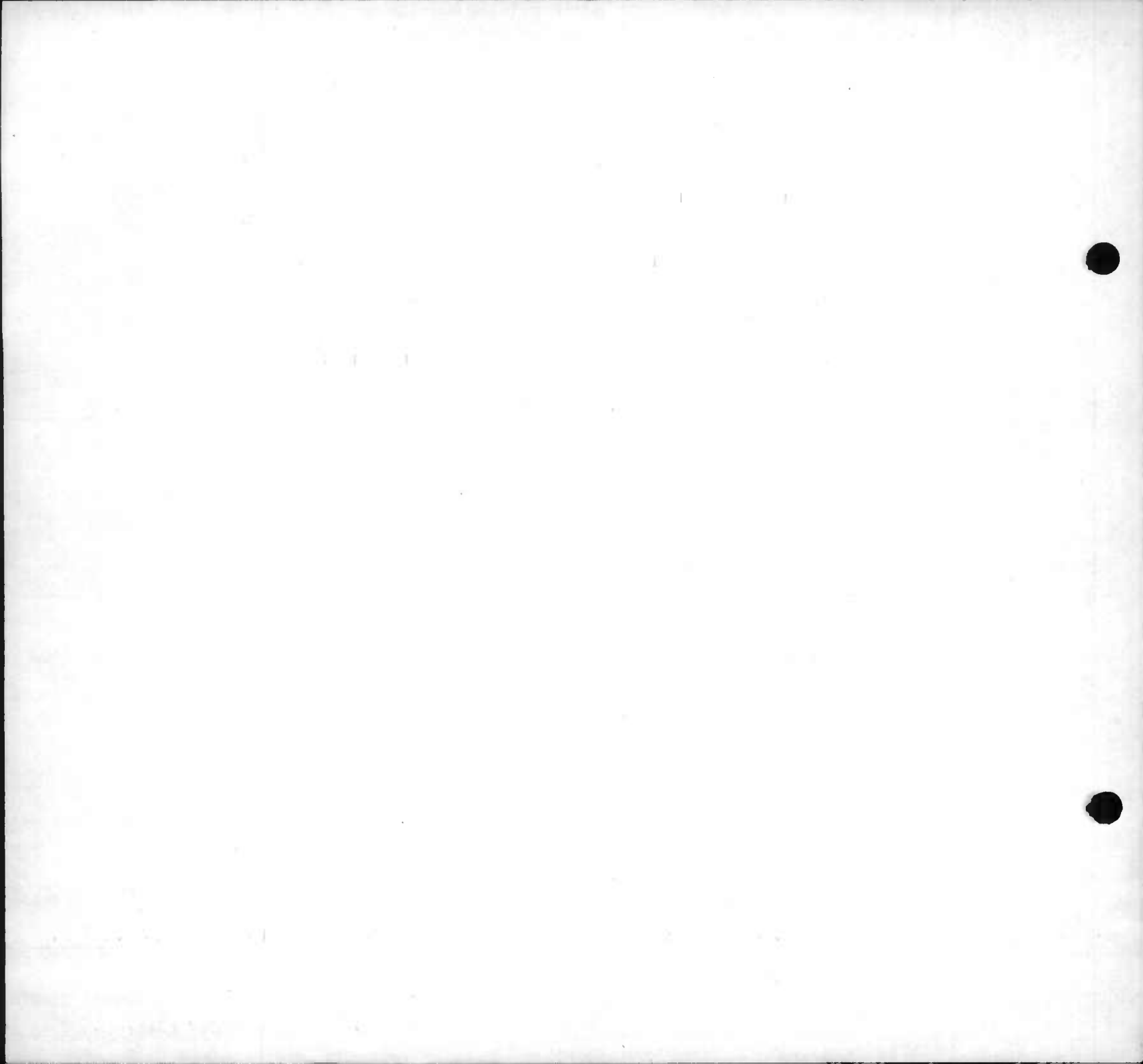
Handwritten text at the bottom of the page, possibly a signature or date.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

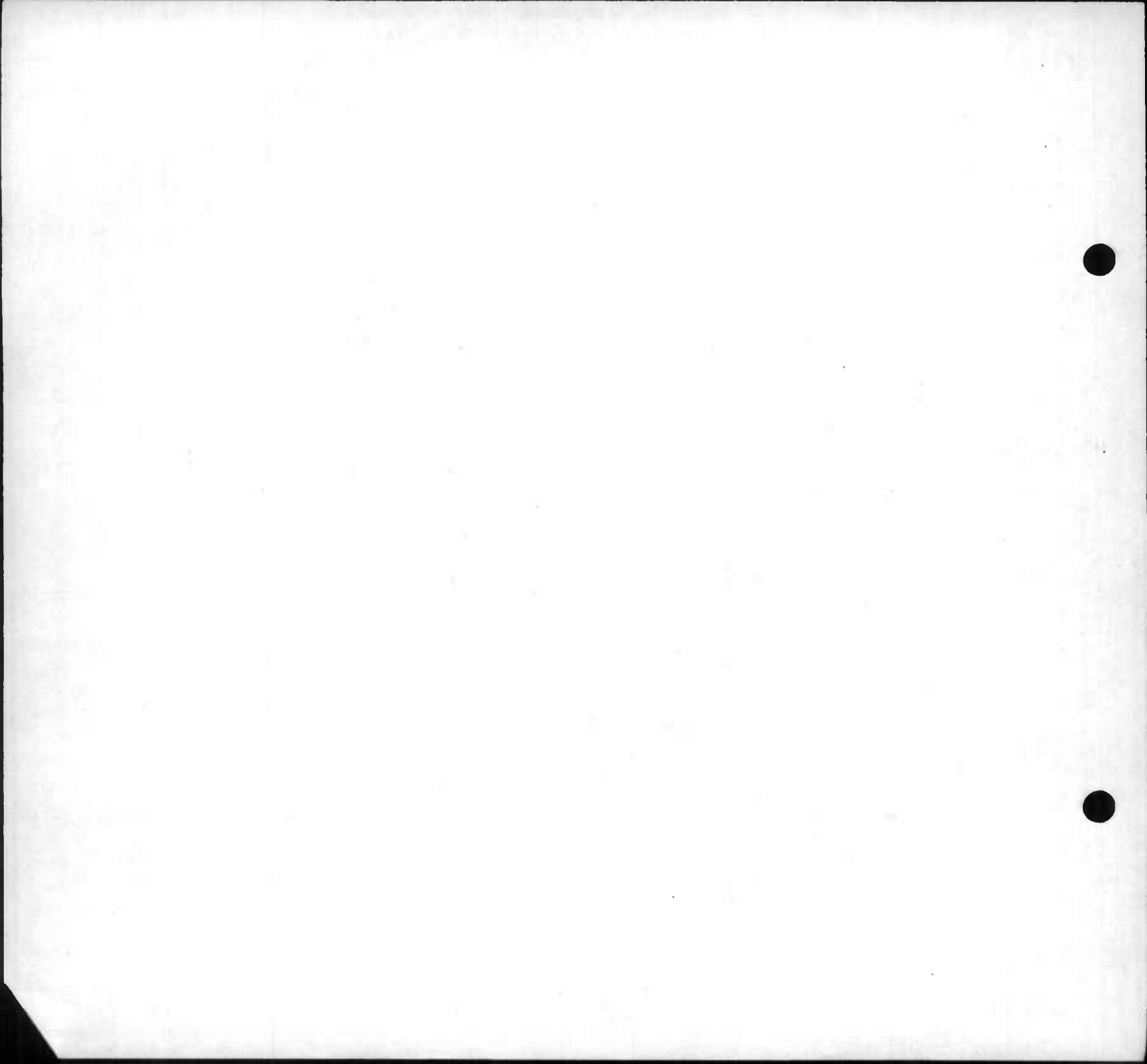
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4613	
BIRTH NO. 65 4613		M.E. CASE NO.		1. NAME OF DECEASED	
1. NAME OF DECEASED (Type or Print) <u>Ross, Norman</u>		2. DATE AND HOUR OF DEATH <u>4/29/65</u>		9 <sup>35</sup> <u>A</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		5-02	
JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 2	
		D. STREET ADDRESS (If rural, give location)		1109 THOMAS STREET	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	NEGRO	SINGLE	4-20-11	54	Labor
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
			Baltimore Md	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
JOHN ROSS		ANNIE FINCH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No.		218-01-6718	Annie Finch		Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3/4/23/65	Homomagic Vastus	Yes	No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
no					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 4/22 19 65 to 4/29 19 65 that (I) (we) last saw the deceased alive on 4/29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
John R. Wagner		4/29/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN R. WAGNER		JOHNS HOPKINS HOSPITAL, BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)	(State)	
Burial	5/3/1965	Not Calvary	Baltimore Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
APR 30 1965	Robert E. Farley M.D.	Choy Wilson	1001 Brantley Ave		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4614</u>	
BIRTH NO. <u>65 4614</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Busch JEROME FRANCIS (Busch)</u>			
2. DATE AND HOUR OF DEATH		<u>4/29/65</u> <u>3 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-10</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>620 McCABE AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>6/18/15</u>	9. AGE (In years lost birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William F. Busch</u>			14. MOTHER'S MAIDEN NAME <u>MARY (UNKNOWN)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>215-01-4992</u>		17. INFORMANT <u>NEPHEW</u>	
18. <u>331 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CEREBRO VASCULAR ACCIDENT</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(he)</del> (this hospital) attended the deceased from <u>4/21</u> 19 <u>65</u> to <u>4/29</u> 19 <u>65</u> , that <del>(he)</del> (we) last saw the deceased alive on <u>4/28</u> 19 <u>65</u> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(did)</del> (did not) view the body after death.					
23A. SIGNATURE <u>William N. Bennett</u> M.D.				23B. DATE SIGNED <u>4/29/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>William N. BENNETT</u> M.D.				23D. ADDRESS <u>Union Memorial Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balti Nat Coul</u>	
24D. LOCATION (City, town, or county) <u>Balti Md</u>		24E. (State) <u>Balti Md</u>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 30 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley M.D.</u>		25C. FUNERAL DIRECTOR <u>Edgar C. Wilson</u>	
25D. ADDRESS					



VS 151-REV. 1/1/65

WALLLEY POPPLE

FRAS 30071871

RECEIVED  
JAN 10 1961  
U.S. AIR FORCE

110101

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4616

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDNA BENNETT

2. DATE AND HOUR PRONOUNCED DEAD

4-26-65

9:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1712 N. Collington Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1712 N. Collington Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept 12 - 1888

9. AGE (In years  
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

John J Brown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

220-09-2791

17. INFORMANT

Mabel Styles

ADDRESS

Same

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

XXXXX

with congestive heart failure

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Peter W. Rieckert

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-26-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/30/1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat Sheds Park

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert E. Finken

24C. FUNERAL DIRECTOR

Elmer O. Wilson

ADDRESS



VALUITY FORGE

MADE IN CHINA

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65 4617

BALTIMORE CITY HEALTH DEPARTMENT

65 4617

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

A. DELORES HOUSLEY

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1965 4:55 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

714 S Grundy St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 27, 1918

9. AGE (In years  
last birthday)

46

10. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Russell Allen

14. MOTHER'S MAIDEN NAME

Caroline L. Krill

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

215-09-5300

17. INFORMANT

ADDRESS

Wm. C. Housley 714 S. Grundy St.,

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Multiple traumatic injuries

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Fagley St. north of Fait Avenue

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

4 20 65 12:15p

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-28-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-3-1965

23C. NAME of CEMETERY or CREMATORY

Balto. National

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 30 1965

R. D. Breiteneker

G. Howard Strong 3207 W. North Ave.,

# WALLACE JOHNSON

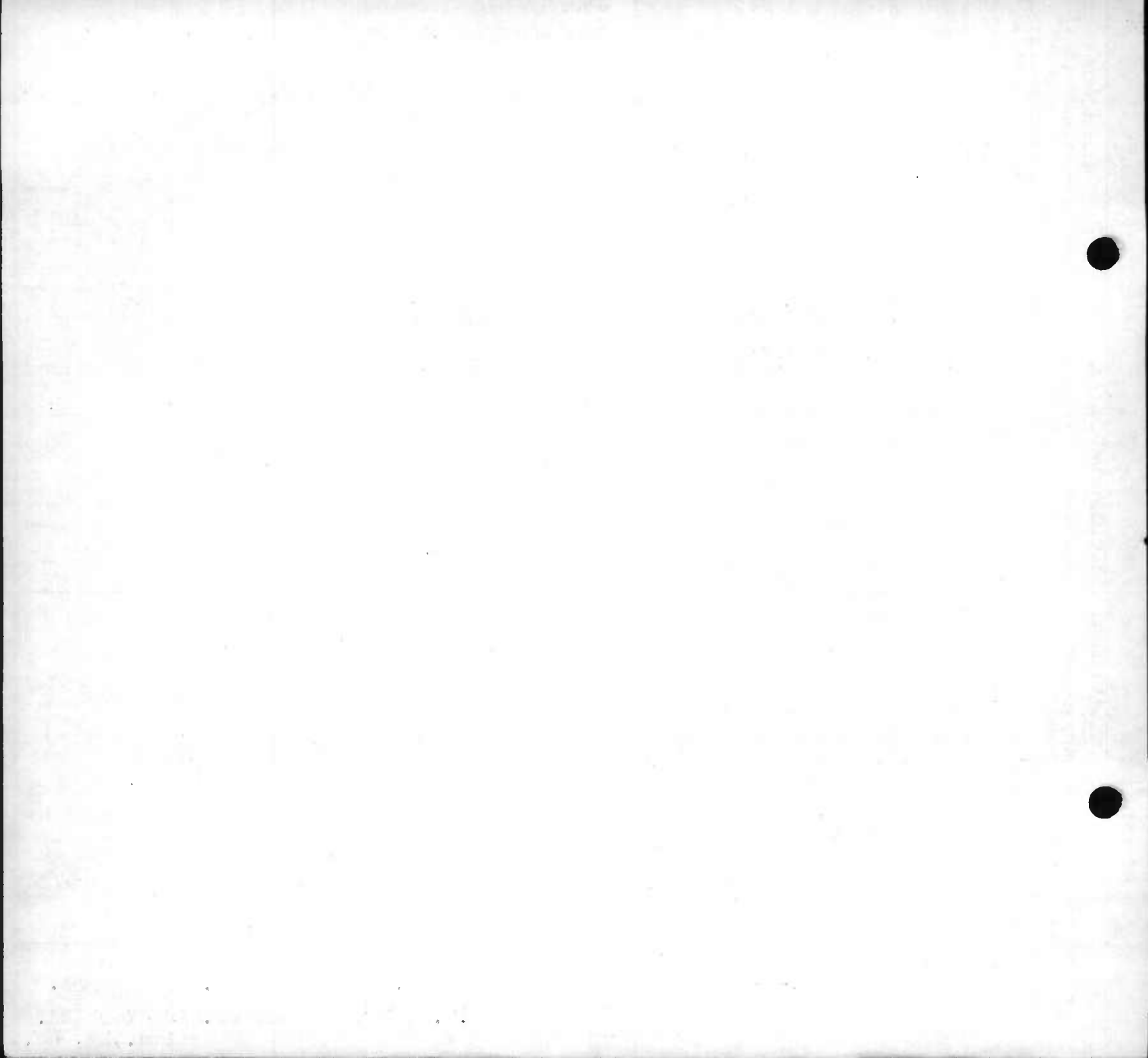
1910-1911

1910-1911

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 4618	
BIRTH NO. 65 4618		M.E. CASE NO. 65 4618		1. NAME OF DECEASED (Type or Print) Conkling, John F		2. DATE AND HOUR OF DEATH 4/29/65 5:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp.				A. STATE Maryland B. COUNTY 27-12			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 6011 SYCAMORE Rd.			
5. SEX M	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5/18/02	9. AGE (In years last birthday) 62	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10B. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Conkling				14. MOTHER'S MAIDEN NAME Emma Francis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-16-5524		17. INFORMANT Wife.		ADDRESS Above	
18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Brain Tumor - Malignant DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 months.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/16 19 65 to 4/29 1965, that (I) (we) last saw the deceased alive on 4/29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard W. Glass M.D.				23B. DATE SIGNED 4/29/65			
23C. PHYSICIAN'S NAME (Type) LEONARD W. GLASS				23D. ADDRESS Maryland General Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-65		24C. NAME of CEMETERY or CREMATORY Chestnut Grove Presby.		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965 Robert E. Glass		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., 12, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
CERTIFICATE OF DEATH												
Registered No. 65 4619												
BIRTH NO. 65 4619												
M.E. CASE NO.												
1. NAME OF DECEASED (Type or Print) Charles A. Krdlecha		2. DATE AND HOUR OF DEATH 4-28-65 11 P. M.										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2637 E. Biddle St		A. STATE Maryland B. COUNTY 8-13										
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore										
		D. STREET ADDRESS (If rural, give location) 2637 E. Biddle St.										
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10-31-73	9. AGE (in years last birthday) 91	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10B. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Czechoslovakia			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Krdlecha				14. MOTHER'S MAIDEN NAME Barbara Unknown								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-0156		17. INFORMANT Mary Krdlecha 2637 E. Biddle St				ADDRESS				
18. 420.1 I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH				
		ANTECEDENT CAUSES						INTERVAL BETWEEN ONSET AND DEATH				
		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						4-22-65				
		II						5 yrs.				
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE										
19A. DATE OF OPERATION 0 NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NONE						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE								
21D. TIME OF INJURY (APPROX.) NONE		21E. INJURY OCCURRED While At Work [ ] Not While At Work [ ] NONE		21F. HOW DID INJURY OCCUR? NONE								
22. I certify that (I) (this hospital) attended the deceased from April 2, 1963 to April 28, 1965, that (I) (we) lost saw the deceased alive on April 28, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
23A. SIGNATURE Emmanuel A. Schimunek M.D.										23B. DATE SIGNED 4-29-65		
23C. PHYSICIAN'S NAME (Type) EMMANUEL A. SCHIMUNEK M.D.										23D. ADDRESS 842 S. EAST AVE BALTO. MD 21214		
24A. BURIAL CREMATION, REMOVAL (Specify) 4-1-65		24B. DATE 4-1-65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town or county) Baltimore		(State) Md 6				
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965		25B. NAME OF REGISTRAR E. Fairbank		25C. FUNERAL DIRECTOR FR. CVACH 850N 900 N. CHESTER ST. S		ADDRESS						

18-10-19

18-10-19

18-10-19

18-10-19

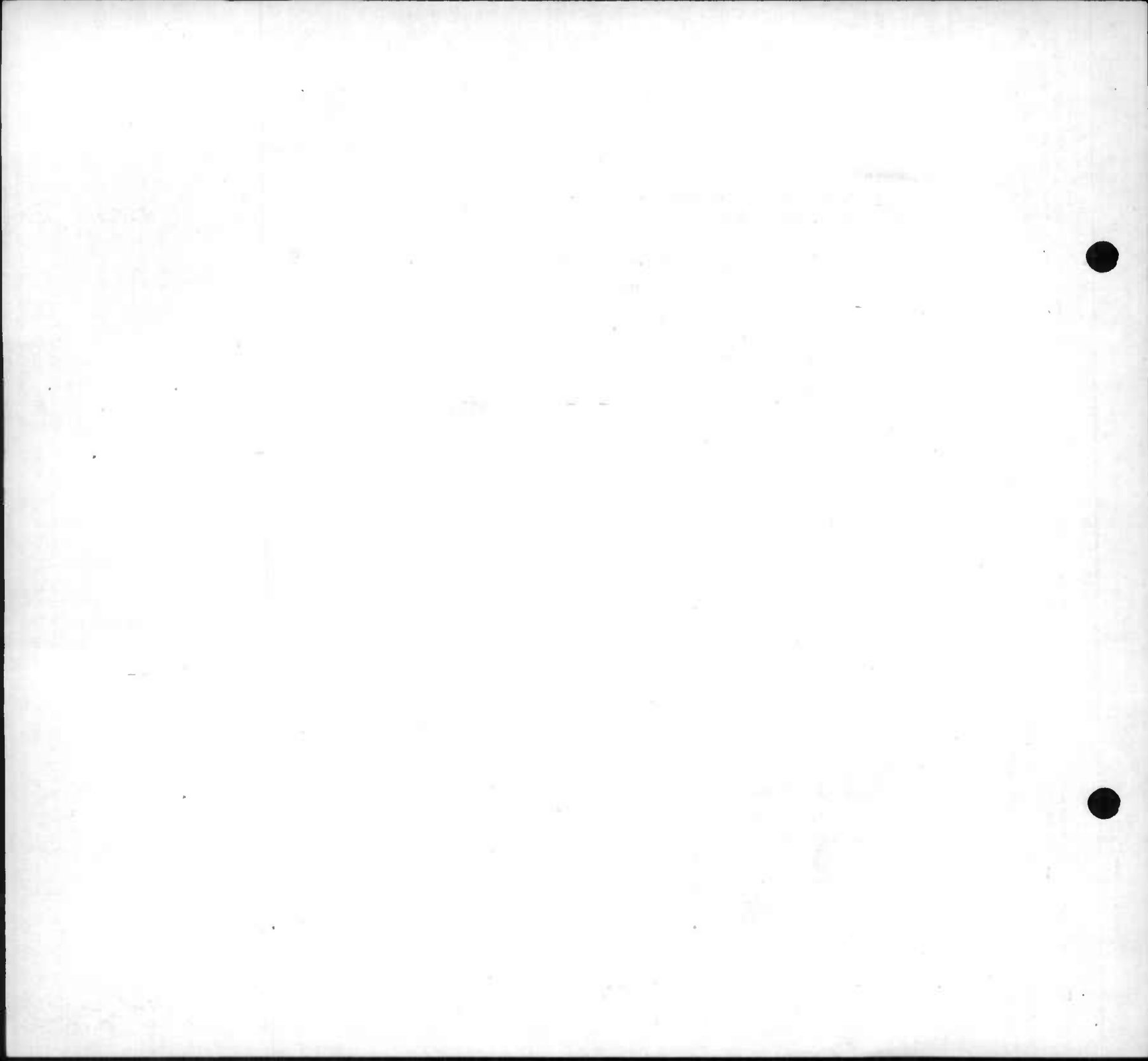
18-10-19

18-10-19

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4620	
BIRTH NO. 65 4620		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Edward Morrison		April 29, 1965 1:25 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Methodist Home 2211 West Rogers Avenue Baltimore, Maryland 21209		Maryland			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		2211 West Rogers Avenue 21209			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	Single	July 13, 1875	89	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired - part time		Stewarts Mens furnishings		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Peter Morrison			Margaret Jane Barranger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No None		215-03-2258		2211 W. Rogers Ave. Methodist Home Records Baltimore, Md. 21209	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic Cardio-vascular Disease		2 yrs.	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
Apr. 1965		Abdominal Aneurysm		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (he) (his hospital) attended the deceased from March 19 65 to Apr. 29 19 65, that (he) (we) last saw the deceased alive on April 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (he) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Clarence W. LeDoux M.D.				4/30/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Clarence W. LeDoux				3023 Eastern Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/1/1965		Loudon Park Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 30 1965		Wm. J. Richmond		Baltimore, Md. 21217	

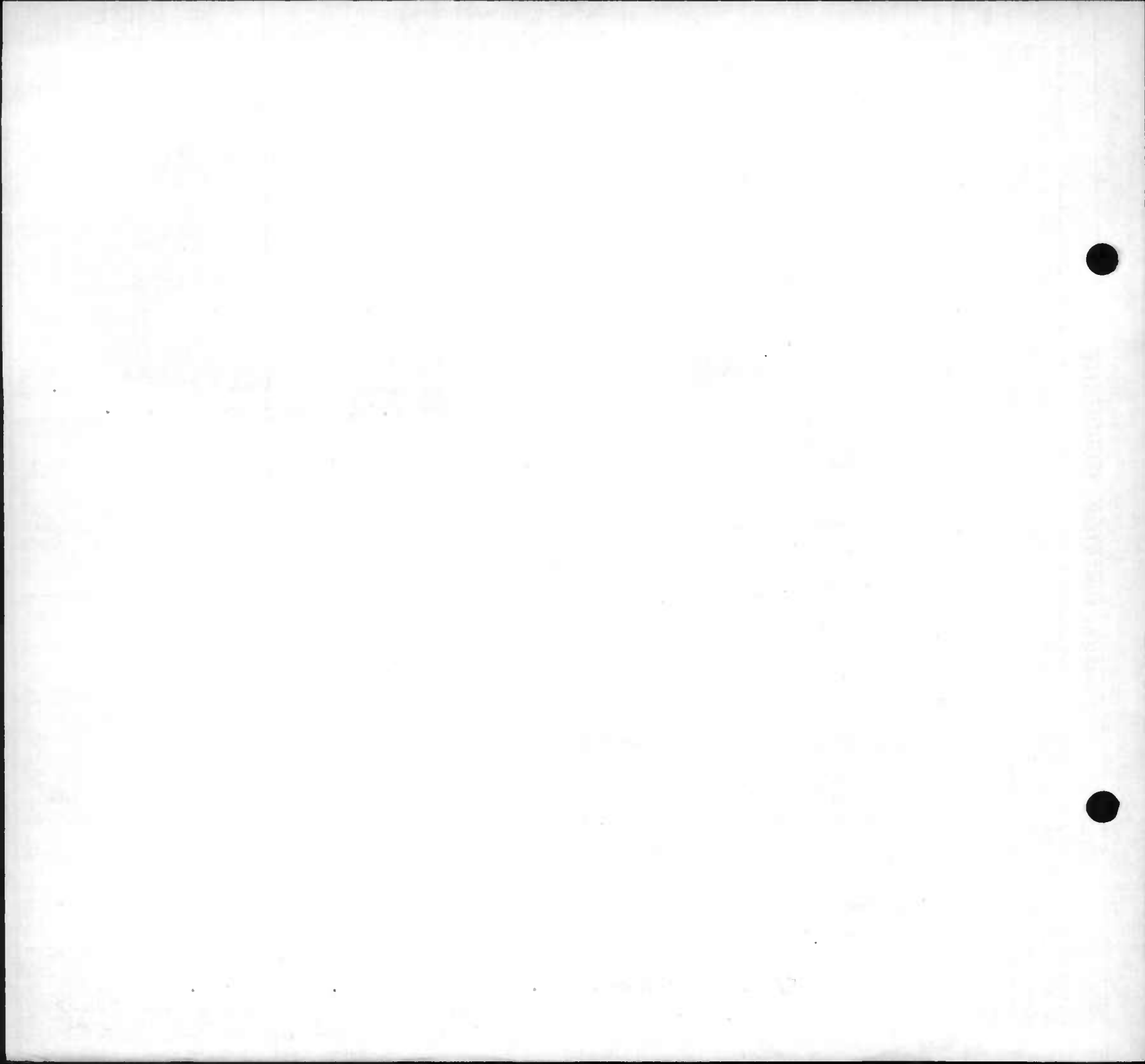




FUNERAL DIRECTOR: IMPORTANT

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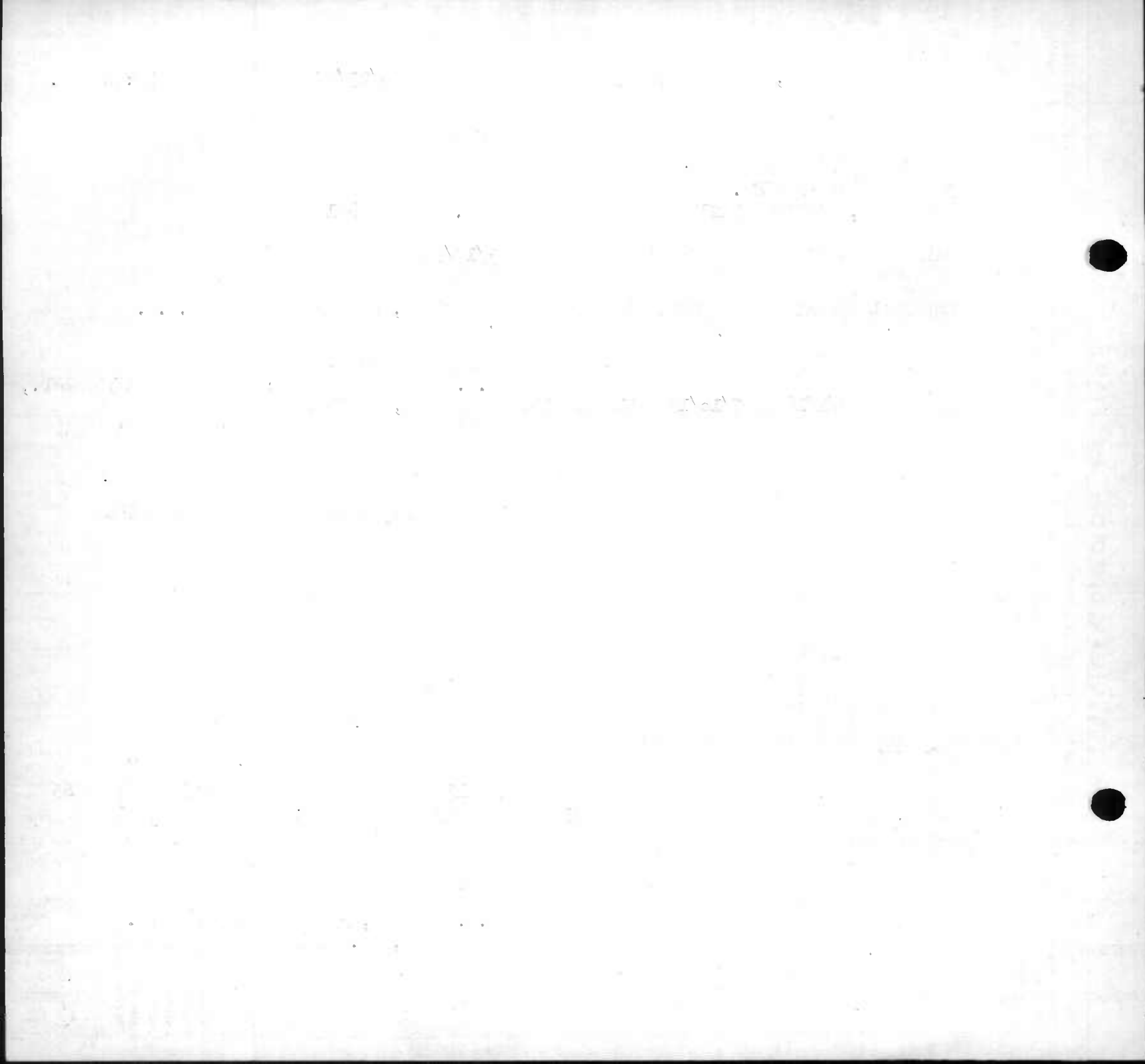
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.5em;">65 4621</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 4621</span>		M.E. CASE NO. <span style="font-size: 1.5em;">65 4621</span>		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.5em;">Mitchell, Leon</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.5em;">4/29/65</span> <span style="font-size: 1.5em;">9</span> <span style="font-size: 1.5em;">P</span> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.5em;">UNIVERSITY OF MARYLAND</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.5em;">VIRGINIA</span> B. COUNTY <span style="font-size: 1.5em;">V-43</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">NEWPORT NEWS</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">1041 HARPERSVILLE RD</span>			
5. SEX <span style="font-size: 1.5em;">F</span>	6. RACE <span style="font-size: 1.5em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.5em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.5em;">5/6/14</span>	9. AGE (In years last birthday) <span style="font-size: 1.5em;">60</span>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">HOUSEWIFE</span>		
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.5em;">North Carolina</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.5em;">USA</span>				
13. FATHER'S NAME <span style="font-size: 1.5em;">JAMES FRANKLIN Haigler</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.5em;">PEARL PRESLEY</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.5em;">Glenwood J. Mitchell</span> ADDRESS <span style="font-size: 1.5em;">1041 Harpersville Rd. Newport New, Va.</span>		
18. <span style="font-size: 1.5em;">157X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">ADENOCARCINOMA/HEAD OF PANCREAS</span>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <span style="font-size: 1.5em;">POST OPERATIVE NECROSIS OF SMALL BOWEL SEPTICEMIA</span>			
19. <span style="font-size: 1.5em;">II</span> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">4/28/65-4/29</span>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.5em;">1 4/28-4/29</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.5em;">CA OF PANCREAS</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">April 28</span> 19 <span style="font-size: 1.5em;">65</span> to <span style="font-size: 1.5em;">April 29</span> 19 <span style="font-size: 1.5em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">April 29</span> 19 <span style="font-size: 1.5em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Joseph J. Mowad</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.5em;">4/29/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.5em;">Joseph J. Mowad</span>				23D. ADDRESS M.D. <span style="font-size: 1.5em;">Baltimore, Md. 21217</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.5em;">Burial</span>		24B. DATE <span style="font-size: 1.5em;">5/2/1965</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.5em;">Peninsula Mem. Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.5em;">Newport New, Va.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">APR 30 1965</span>		25B. NAME of REGISTRAR <span style="font-size: 1.5em;">Wm. J. Dickerson</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Wm. J. Dickerson</span>		ADDRESS <span style="font-size: 1.5em;">Baltimore, Md. 21217</span>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="float: right;">65 65494622</span>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <span style="float: right;">Registered No. 6565494622</span>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CORNISH, HAMPTON (NMI)</b>		2. DATE AND HOUR OF DEATH <b>4/23/65 10:20 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>94</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>PASADENA 52-00</b> D. STREET ADDRESS (If rural, give location) <b>RT. 4 BOX 491</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3/15/96</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEMICAL OPERATOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>CAMBRIDGE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>HAMPTON CORNISH</b>		
14. MOTHER'S MAIDEN NAME <b>EMILY CORNISH</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 9/1/18 TO 7/10/19</b>		
16. SOCIAL SECURITY NO. <b>215 09 6378</b>			17. INFORMANT ADDRESS <b>V.A. HOSPITAL RECORDS; 3900 LOCH RAVEN BLVD., BALTIMORE, MARYLAND 21218</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>LOBAR PNEUMONIA</b> <b>BRONCHOGENIC CARCINOMA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>9 MONTHS</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 13 1965</b> to <b>APRIL 23 1965</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>APRIL 23 1965</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>M.D. V.A. HOSPITAL, 3900 LOCH RAVEN BLVD. BALTIMORE, MD. 21218</b>				23D. ADDRESS <b>BALTIMORE, MD. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-27-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
24D. LOCATION <b>MD.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 20 1965</b>		25B. NAME OF REGISTRAR <b>Belington S. Phillips</b>	
25C. FUNERAL DIRECTOR <b>1727 N. Monroe St.</b>		25D. ADDRESS			



41-94-08

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

65 4623

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 4623

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Willie Askew

2. DATE AND HOUR OF DEATH

April 26, 1965

4:55

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

701 W. Mulberry Street 21201

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-22-1916

9. AGE (In years  
last birthday)

49

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Turner Askew

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

002, 1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Tuberculosis of Lung, Left  
DUE TO

12 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Long standing Kidney Disease  
Operation-Left Pneumonectomy

19A. DATE OF OPERATION

March 31, 1965

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDLung  
Diffuse Disease of Left

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 24, 1964 to April 26, 1965  
that (I) (we) last saw the deceased alive on April 26, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Donald Baltzan

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

April 26, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Donald Baltzan

23D. ADDRESS

M.D.

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-30-65

24C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pl. Baltimore

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

25B. NAME OF REGISTRAR

Robert E. Fadden

25C. FUNERAL DIRECTOR

Wilmington &amp; Phillips 1727 N. Monroe St.

ADDRESS

ALCOHOL

100

BIRTH NO. 65 4624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4624

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CAIN WATSON

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1965 8:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1725 Poplar Grove St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-30-1916

9. AGE (In years  
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Clayton, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William L. Watson

14. MOTHER'S MAIDEN NAME

Maggie Watson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

213-10-9178

17. INFORMANT

ADDRESS

Georgia Watson 1725 Poplar Grove St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Generalized tuberculosis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-28-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-1-65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

Baltimore

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Rudiger Breitenacker

24C. FUNERAL DIRECTOR

Walter S. Phillips 1727 N. Monmouth St.

ADDRESS

WALTER BORDO

20-11-12  
Lester, Mr.  
Chicago, Ill.

2-1-12  
Lester, Mr.  
Chicago, Ill.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 3 65 4625				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4625	
1. NAME OF DECEASED (Type or Print) <b>Alma E. George</b>				2. DATE AND HOUR OF DEATH 4-28-65 6:00 PM.					
3. PLACE OF DEATH (In Baltimore, Maryland, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-05</b>					
5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>				8. DATE OF BIRTH <b>12-8-1889</b>		9. AGE (In years last birthday) <b>75</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CONRAD GEORGE</b>				14. MOTHER'S MAIDEN NAME <b>ANNA LOEWER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>218 38 2749</b>		17. INFORMANT ADDRESS <b>Carl M. George, 1801 Chilton St</b>			
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>ISCUD</b> (B) _____ (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4-16</b> 19 <b>65</b> to <b>4-28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Jacques P. Caldwell</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>4-28-65</b>					
23C. PHYSICIAN'S NAME (Type) <b>Jacques P. Caldwell</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 1/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Searles</b>		25C. FUNERAL DIRECTOR <b>W. J. Searles</b>		25D. ADDRESS <b>4101 Edmondson Ave</b>			

Birth Certificate A-17438 - 5th child  
Female born 12-8-1889 to Conrad & Anna George  
5-4-65 M.H.

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4626		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO. (4)				1. NAME OF DECEASED <b>Effie I. Kretsinger</b> (Type or Print) <b>EFFIE KRETSINGER</b>			
2. DATE AND HOUR OF DEATH <b>April 29, 1965</b> <b>9:45 P.M.</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME AND HOSPITAL</b>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-04</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> <b>29</b>		D. STREET ADDRESS (If rural, give location) <b>400 OLD ORCHARD RD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>3-12-79</b>	9. AGE (in years last birthday) <b>86</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>GEORGE BREITWEISER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET BRITHSINGER</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>FRANCES KRETSINGER</b>	
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 DAYS?</b>				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 8</b> 19 <b>65</b> to <b>April 29</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 29</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>C. In Lee</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/29/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CHOONG IN LEE</b>				23D. ADDRESS <b>CHURCH HOME AND HOSPITAL.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 2/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Smithburg</b>		24D. LOCATION (City, town, or county) (State) <b>Smithburg, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkley</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D.</b>		ADDRESS <b>4101 Edmondson Ave</b>	

GEORGE KRETSINGER  
Widow

F W WIDOWED

MARGARET B. KRETSINGER  
FRANCE KRETSINGER

MARYLAND AMERICAN

3-12-77

AT THE SKYWARD

CHURCH HOME AND

CHOONG IN LEE

CHURCH HOME AND

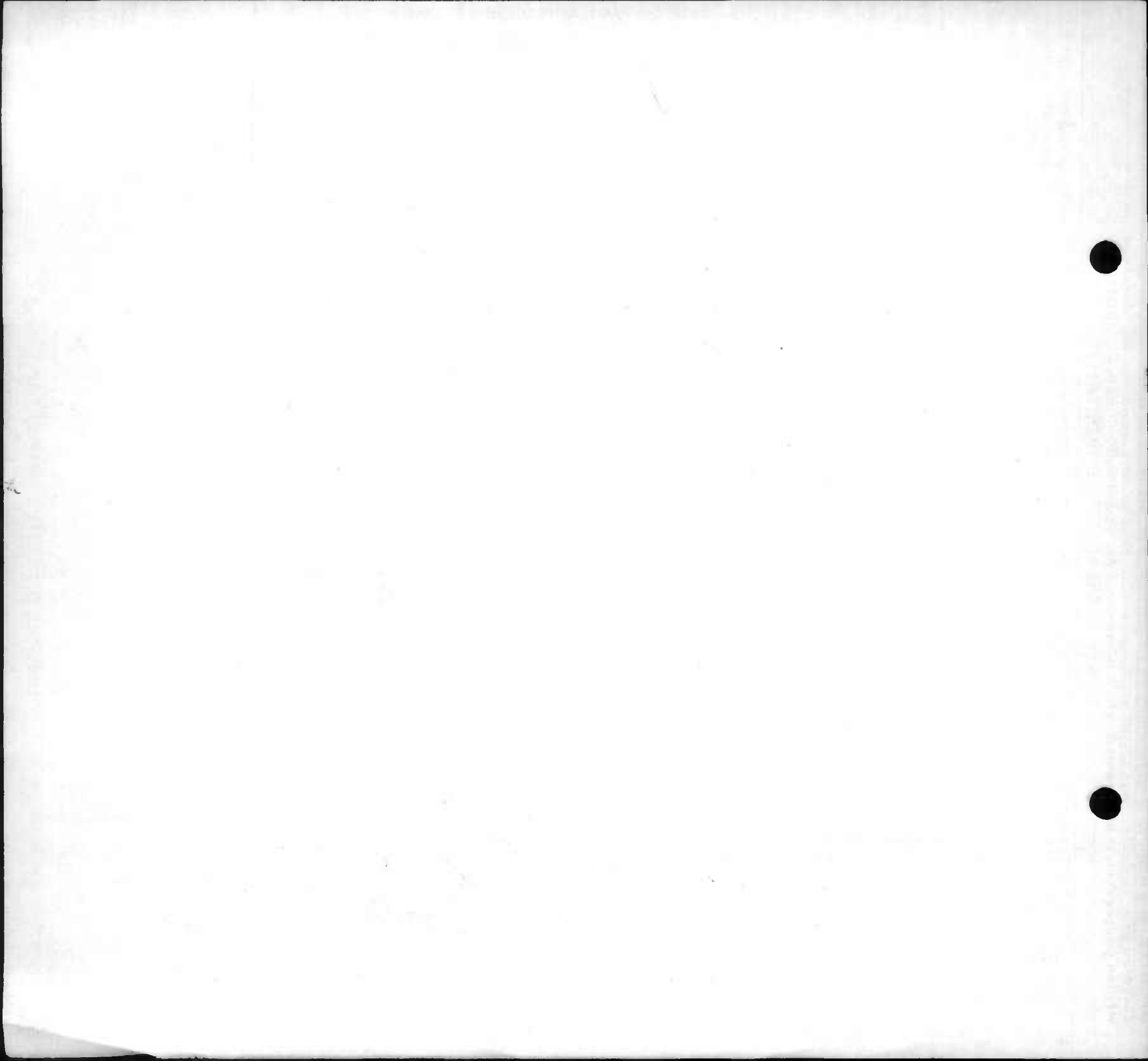
Apr 21  
8 1977

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4627	
BIRTH NO.				65 4627	
M.E. CASE NO.				65 4627	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
FREDA JOHNSON ROGERS				4-28-1965 2:30 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
1122 LEADENHALL ST				MD 23-01	
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FEMALE Colored MARRIED				BALTIMORE	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				D. STREET ADDRESS (If rural, give location)	
Homemaker				1122 LEADENHALL ST	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH	
At Home				10-2-1905	
11. BIRTHPLACE (State or foreign country)				9. AGE (In years last birthday)	
A.A. Co. MD				57	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME	
U.S.N.				James Turner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
no					
17. INFORMANT				ADDRESS	
ARTHUR ROGERS				1122 LEADENHALL ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO	
ANTECEDENT CAUSES				Cardio Vascular Disease probably days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO	
				Coronary Thrombosis	
II				(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from April 22 1965 to April 28 1965, that (I) (we) last saw the deceased alive on April 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. yes				21F. HOW DID INJURY OCCUR?	
23A. SIGNATURE				23B. DATE SIGNED	
[Signature]				4/29-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
[Signature]				403 Med Arts Bg	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				5/2/65	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Mt. Calvary				Baltimore 25 md	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
APR 30 1965				Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR				ADDRESS	
[Signature]				638 N. E. Lombard St	



1

65 4628

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4628

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES COLLENS

2. DATE AND HOUR PRONOUNCED DEAD

April 27, 1965

3:30 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

30 N. Temple Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

30 N. Temple Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

5-8-1913

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ATLANTA, GA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Alston

14. MOTHER'S MAIDEN NAME

Francis Alston

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

18-07-0516

17. INFORMANT

Jonah Alston

ADDRESS

2119 Sinclair La. #13

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Chronic ethylism

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Hypertensive cardiovascular disease and  
diabetes mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-27-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-30-65

23C. NAME OF CEMETERY or CREMATORY

Baldwin Nat'l

23D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

R. C. G. F. F. F.

24C. FUNERAL DIRECTOR

Morton J. Dyett

ADDRESS

1701 Laurens

WALTER P. HUGHES

WALTER P. HUGHES

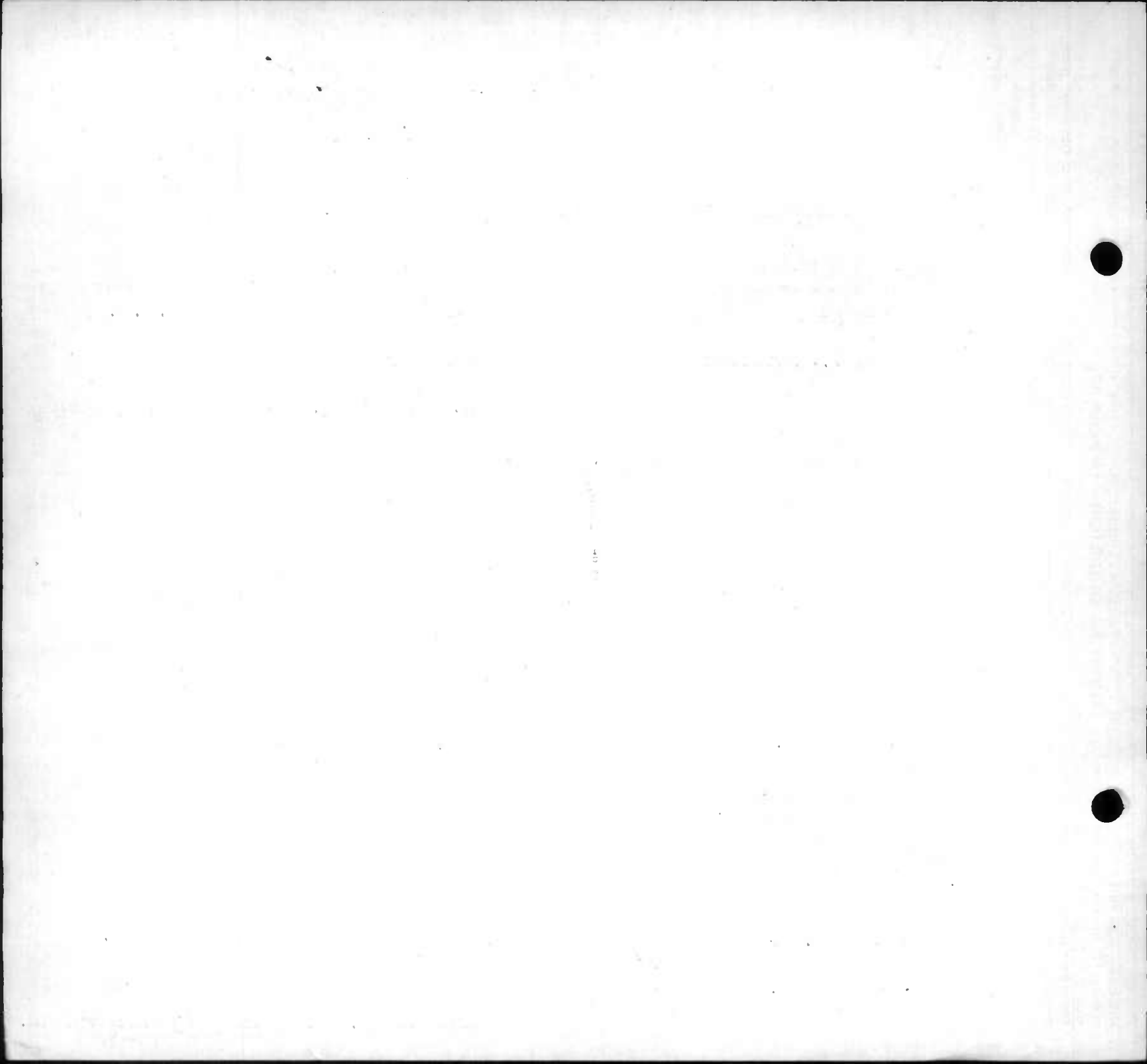
WALTER P. HUGHES



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65-4629					REGISTERED NO.		65 4629		
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Margaret Virginia Webster					April 28, 1965 12:40 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE				
					Maryland				
Maryland General Hospital					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					5608 Mayview Avenue				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
female	white	widowed	Sept 5, 1894	70					
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Housewife			Wenona, Maryland			U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joseph T. Harrison					Alverta Parks				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
							Mr. Russell E. Webster, 5701 Baatbury		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
					Acute Myocardial Infarction				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					Arteriosclerotic Heart Disease				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(B) DUE TO				
					(C)				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
D					No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 5/20 1957 to 4/28 1965, that (I) (we) last saw the deceased alive on 3/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
Albert B. Bradley								4/30/65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Albert B. Bradley					M.D. 4900 Belair Road, Baltimore, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial			5/1/65		Baltimore Cemetery		Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS	
APR 30 1965			Robert E. Johnson		Leonard J. Ruck Inc			5305 Harford Rd.	



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EMMET

NELSON

2. DATE AND HOUR PRONOUNCED DEAD

April 29, 1965

7:55 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

White Marsh

D. STREET ADDRESS (If rural, give location)

676 Bangert Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

8-28-1915

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Manager-United Steel Company

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Nelson

14. MOTHER'S MAIDEN NAME

Estella Stagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

217018859

17. INFORMANT

Ruth L. Nelson

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Emphysema  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Bronchial Asthma.  
DUE TO

(C)

MEDICAL CERTIFICATION

ii  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

23B. DATE

5-3-65

23C. NAME OF CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 30 1965

24B. NAME OF REGISTRAR

Robert E. Faby

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc.

ADDRESS

Baltimore, Md.

WALLER ROUGE

DATE

11-1-55

WALLER ROUGE

WALLER ROUGE

WALLER ROUGE

WALLER ROUGE

WALLER ROUGE

WALLER ROUGE

11-1-55

WALLER ROUGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4631				
BIRTH NO. 65 4631		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <u>James R. Gately</u>		2. DATE AND HOUR OF DEATH <u>30 April 1965 12:15 A.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt.</u>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland Gen Hosp</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md. 5300</u>				
D. STREET ADDRESS (If rural, give location) <u>6000 Westwood Ave.</u>					5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M</u>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Master</u>					10B. KIND OF BUSINESS OR INDUSTRY				
13. FATHER'S NAME <u>Edward Gately</u>					14. MOTHER'S MAIDEN NAME <u>Estella Crawford</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>					16. SOCIAL SECURITY NO. <u>717-09-0011</u>				
17. INFORMANT <u>Theresa H. Gately</u>					ADDRESS <u>SAME</u>				
18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Recurrent Ca of Lung</u>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>4/22/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Elective</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>4/19/65</u> 19 to <u>4/30/65</u> 19, that (I) (we) last saw the deceased alive on <u>4/29/65</u> 19 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <u>[Signature]</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>30 April 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Name]</u>					23D. ADDRESS M.D. <u>[Address]</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>5/3/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer</u>			24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>		
25A. DATE REC'D BY HEALTH/DEPT <u>APR 30 1965</u>		25B. NAME OF REGISTRAR <u>[Name]</u>			25C. FUNERAL DIRECTOR <u>[Name]</u>				
					ADDRESS <u>5305 Hayford</u>				

Washing on Hoss

M N M

Station Master

Edward Gately

5

215-00-0000

Receipt of 100

~~Station Master~~

Estelle Cram

2-11-14

Washing on Hoss

h 2

For 100

10/25/14

*Edward Gately*

4/10/14

4/10/14

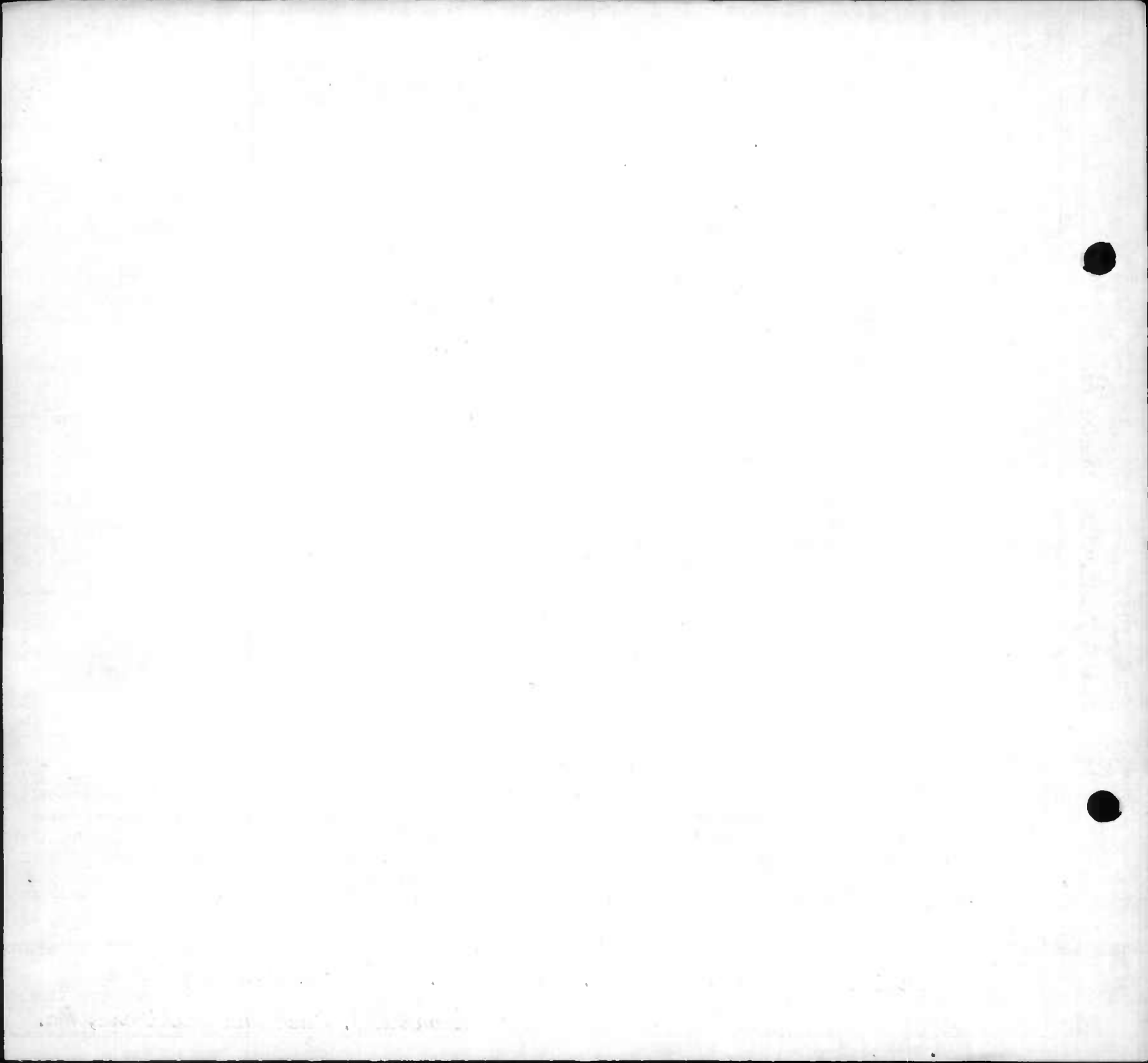
4/10/14

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4632		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No. 65 4632	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) ARCEO, JOSEPH BERNARD		2. DATE AND HOUR OF DEATH APR 24, 1965 10:12 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE N.J. B. COUNTY V-27	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)	
U.S. PUBLIC HEALTH SERVICE HOSPITAL WYMAN PK. DRIVE & 31ST. STREET		BELLMAWR		433 FIRST AVE.	
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-21-14	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		10B. KIND OF BUSINESS OR INDUSTRY SEAFARER		11. BIRTHPLACE (State or foreign country) CALIFORNIA, USA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME INOS ARCEO		14. MOTHER'S MAIDEN NAME CHARLOTTA CLARK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 526 053754		17. INFORMANT RECORDS, USPHS HOSPITAL, BALTIMORE, MD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of Stomach DUE TO (B) DUE TO (C) Multiple Hepatic metastases		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAR. 27, 1965 to APR 24, 1965, that (I) (we) last saw the deceased alive on APR 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James H. Frank.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/25/65	
23C. PHYSICIAN'S NAME (Type) JAMES H. FRANK		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/28/65		24C. NAME OF CEMETERY or CREMATORY New St. Mary's Cem.	
24D. LOCATION (City, town, or county) (State) Bellmawr, New Jersey		25A. DATE REC'D BY HEALTH DEPT. APR 30 1965		25B. NAME OF REGISTRAR R. E. Farley, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md.		25D. ADDRESS			

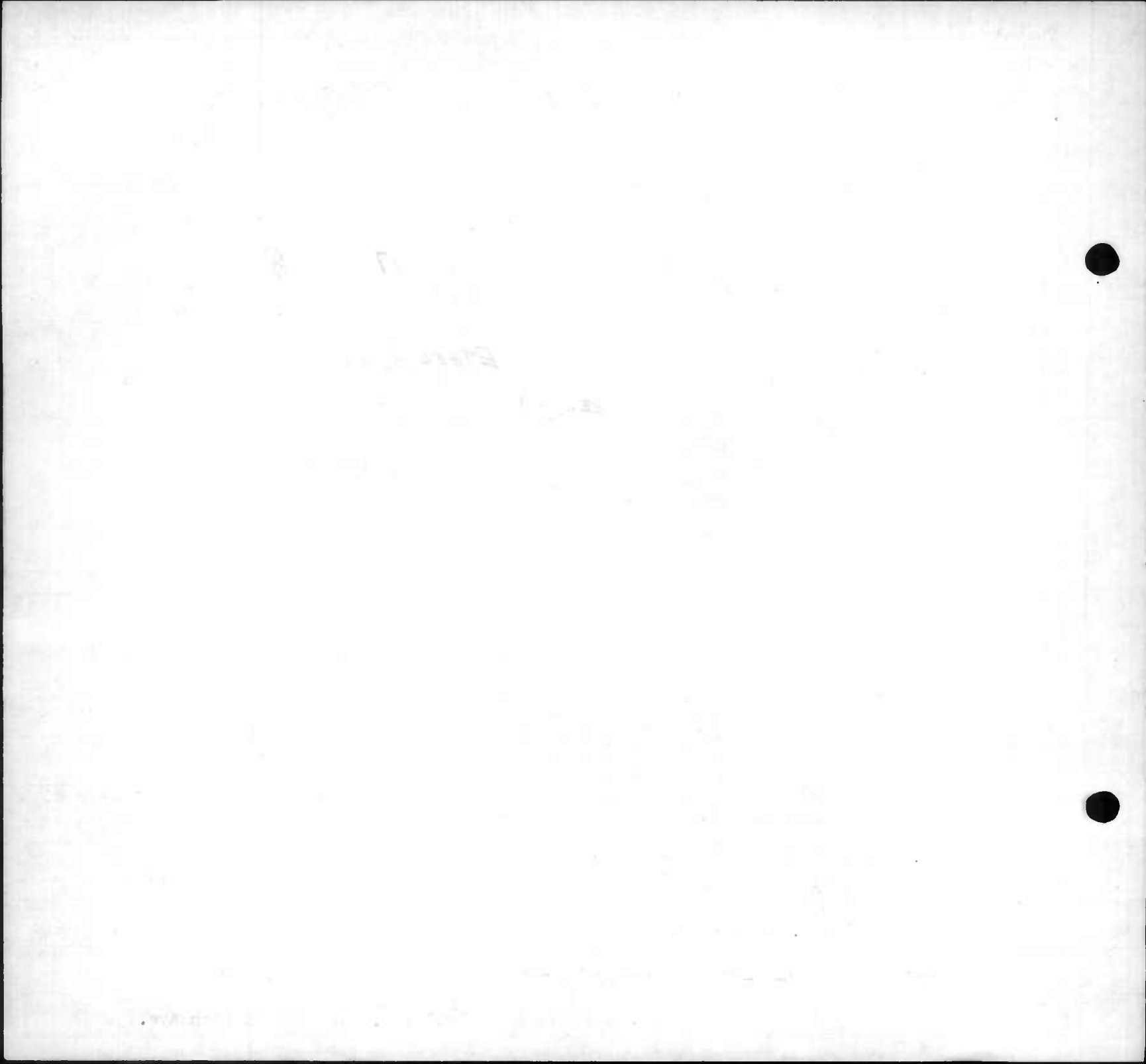




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

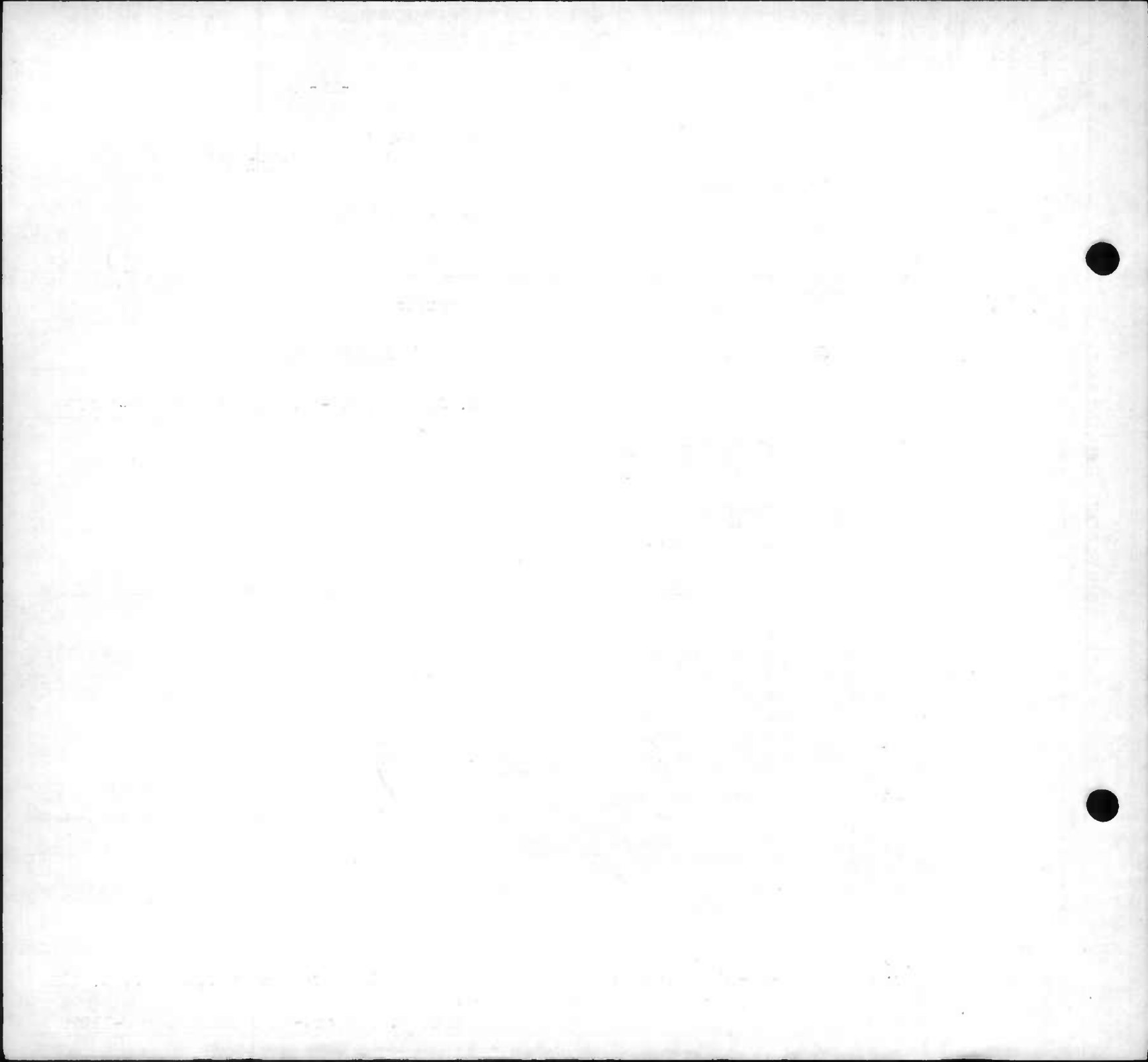
BALTIMORE CITY HEALTH DEPARTMENT																
65 4633					CERTIFICATE OF DEATH					Registered No. 65 4633						
BIRTH NO.					M.E. CASE NO.					2. DATE AND HOUR OF DEATH						
1. NAME OF DECEASED (Type or Print) <b>ROBERTA B. BELLAMY</b>					APRIL 26, 1965					7 <sup>00</sup> P.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION <b>MONTEBELLO STATE HOSPITAL</b>					A. STATE <b>MD.</b>					B. COUNTY <b>20-07</b>						
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					D. STREET ADDRESS (If rural, give location) <b>328 ALLENDALE ST.</b>						
5. SEX <b>F</b>		6. RACE <b>C</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>4-7-1917</b>		9. AGE (In years last birthday) <b>48</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE MOTHER</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>COLLEGE</b>					11. BIRTHPLACE (State or foreign country) <b>MD.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>COLLIE BOSTICK</b>					14. MOTHER'S MAIDEN NAME <b>ETHEL HILL</b>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>215-225660</b>					17. INFORMANT <b>Pt. (chart.)</b>					ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>170X I</b>					CAUSE OF DEATH (A) <b>CARCINOMA OF BREAST</b> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>4 YRS</b>						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO											
(C) DUE TO																
II																
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>YES</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that <del>my</del> (this hospital) attended the deceased from <b>4-12</b> 19 <b>65</b> to <b>4-26</b> 19 <b>65</b> , that <del>my</del> (we) last saw the deceased alive on <b>4-26</b> 19 <b>65</b> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>my</del> (We) (did) (did not) view the body after death.																
23A. SIGNATURE <b>Irving L. Cooperstein</b>					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>4-26-65</b>						
23C. PHYSICIAN'S NAME (Type) <b>Irving L. Cooperstein</b>					M.D. <b>MONTEBELLO STATE HOSP., BALTO., MD.</b>					23D. ADDRESS						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>4-29-65</b>					24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>					24D. LOCATION (City, town, of county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 30 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>					25C. FUNERAL DIRECTOR <b>Charles R. Law</b>					ADDRESS <b>802 Madison Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4634	
BIRTH NO. 65 4634		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Girl Meyers		2. DATE AND HOUR OF DEATH 4-28-65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213			
D. STREET ADDRESS (If rural, give location) 2753 Pelham Avenue					
5. SEX F	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 4/28/65	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Meyers			14. MOTHER'S MAIDEN NAME Amelia Streett		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. John Meyers-2753 Pelham Avenue-21213		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) I 276X CAUSE OF DEATH (A) IMMATUREITY (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 1 Hour					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6:20 pm 4/28 1965 to 7:20 pm 4/28 1965, that (I) (we) last saw the deceased alive on 4/28/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C. E. Hubbard				23B. DATE SIGNED 4/29/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-30-65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave., Balto., Md. 21234					
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965		25B. NAME OF REGISTRAR Robert E. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

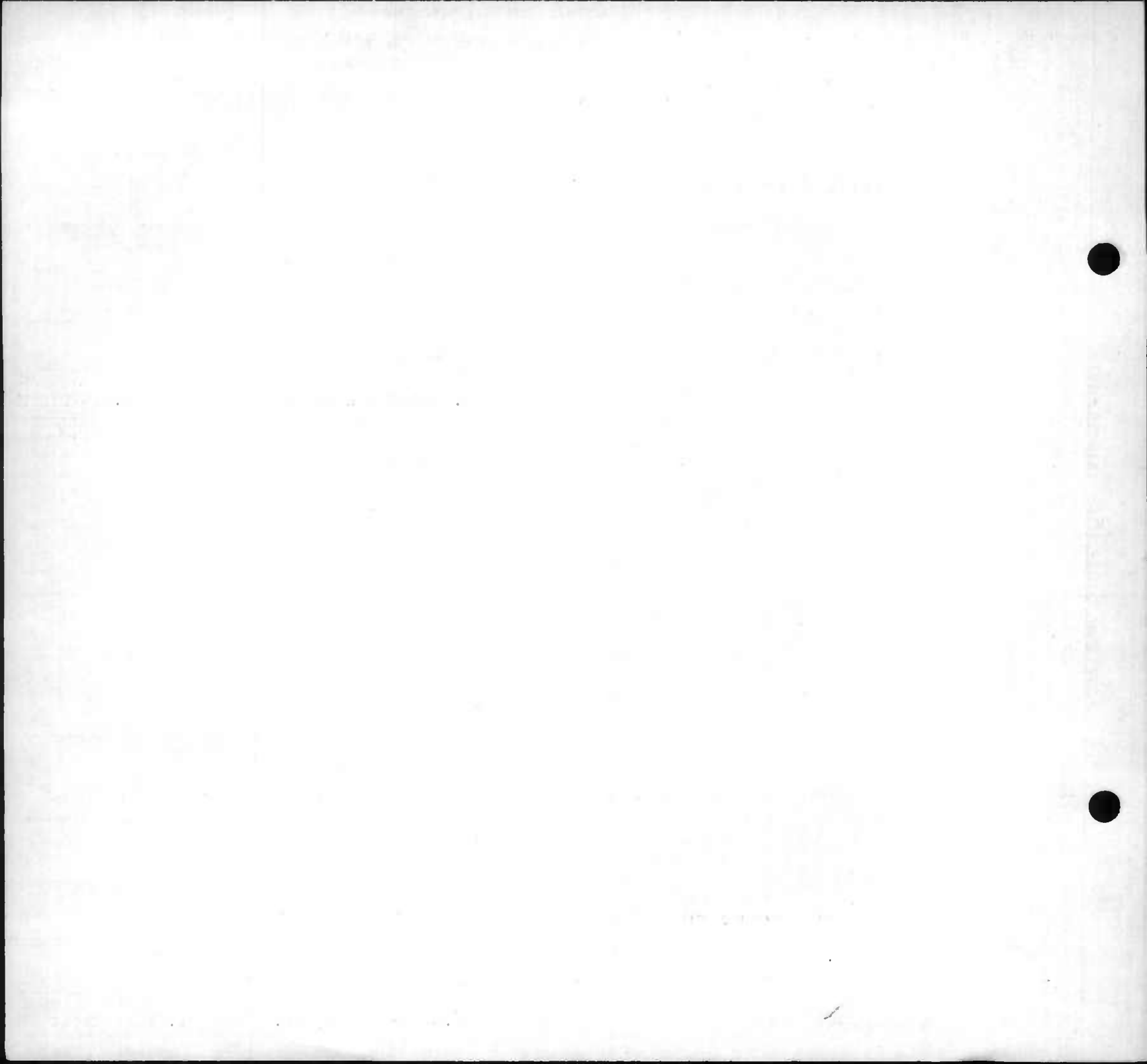
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4635	
BIRTH NO. 65 4635		CERTIFICATE OF DEATH		65 4635	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Chester Smelser		4-27-65 10:05 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
Baltimore City Hospitals		Maryland		15-13	
4940 Eastern Avenue		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
Baltimore, Maryland #21224		D. STREET ADDRESS (If rural, give location)		2713 Classen Avenue #21215	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Male	White	Separated	1897 10-17-96	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
unknown				MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
unknown		unknown		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212102163		RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Cardia Arrest		4 Minutes	
ANTECEDENT CAUSES		(B) Cor Pulmonale		5 Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Chronic Obstructive Pulmonary Disease		20 Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pulmonary Tuberculosis, Arrested			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-10 19 64 to 4-27 19 65, that (I) (we) last saw the deceased alive on 4-27- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Dr. Charles Carpenter		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		4-27-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Charles Carpenter		4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/30/65		LOUDON PARK CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 30 1965		Robert E. Hubbard		Howard H. Hubbard 4107 Wilkens Ave. 21229	

Deceased Birth Certificate. C. Bowens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.5em;">65 4636</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 4636</span>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">APRIL 30, 1965 4:35 A.M.</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WEHLAND, MARTHA E</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">90</span>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">LINTHICUM HEIGHTS 5200</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">213 LAUREL ROAD</span>			
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-4-90</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">74</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">House wife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">BENJAMIN H. LANE</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Md <span style="font-size: 1.2em;">Mrs. Elizabeth Morgan, 213 Laurel Rd. LINTHICUM</span>	
18. <span style="font-size: 1.2em;">422.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">STROKE &amp; PULMONARY INFARCTION</span>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">ASCVD</span>		(A) DUE TO			
		(B) DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Pneumonia?</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">-</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">-</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">APRIL 25 1965</span> to <span style="font-size: 1.2em;">APRIL 30 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">APRIL 30 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Chi Tsung Su</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">4/30/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DR. CHI-TSUNG SU</span>				23D. ADDRESS <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5-3-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Cedar Hill Cemetery</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie, Md</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 30 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Bailey</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. Cook-Brooks, Inc., 1217 St. Paul Street</span>	

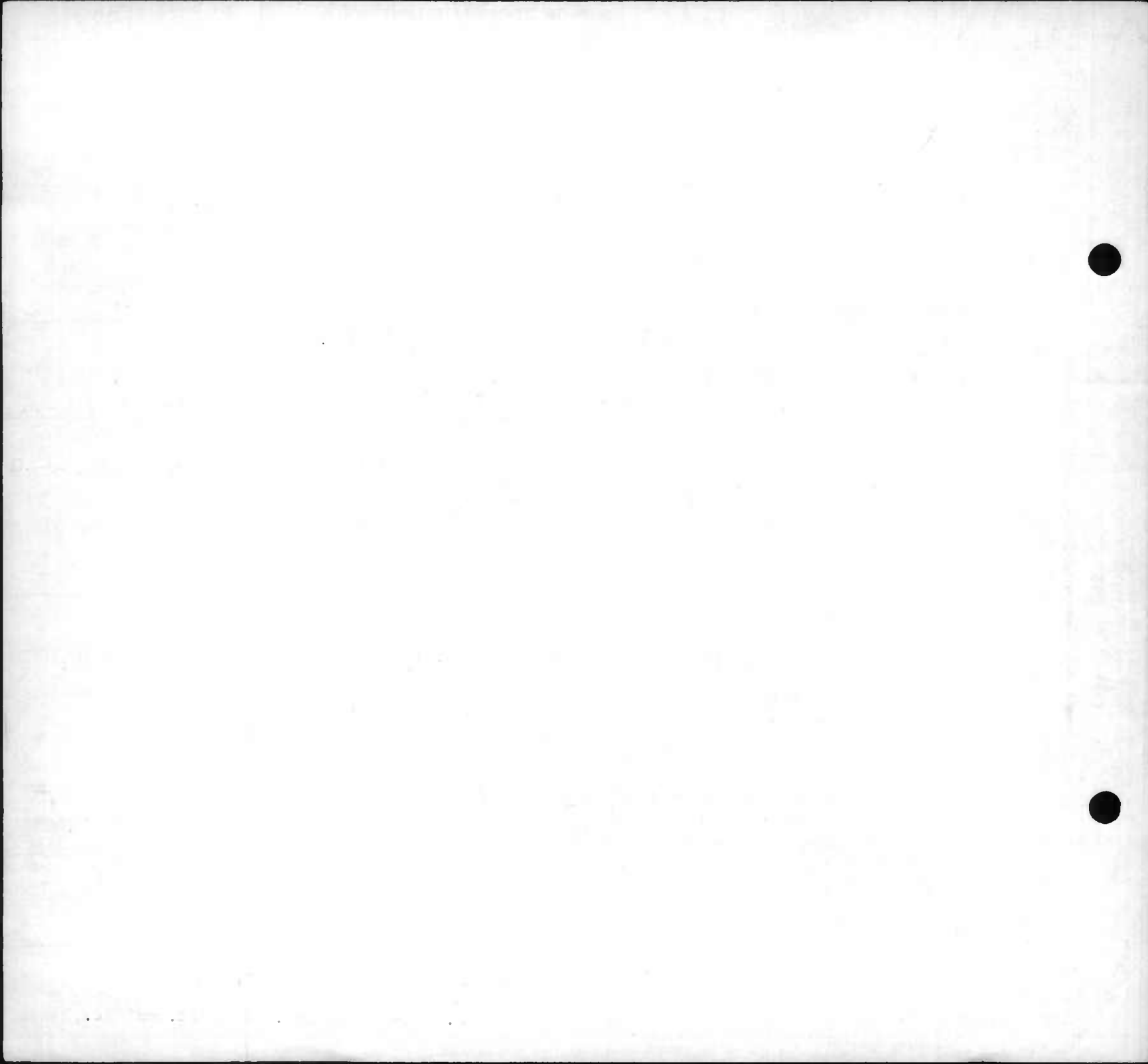




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

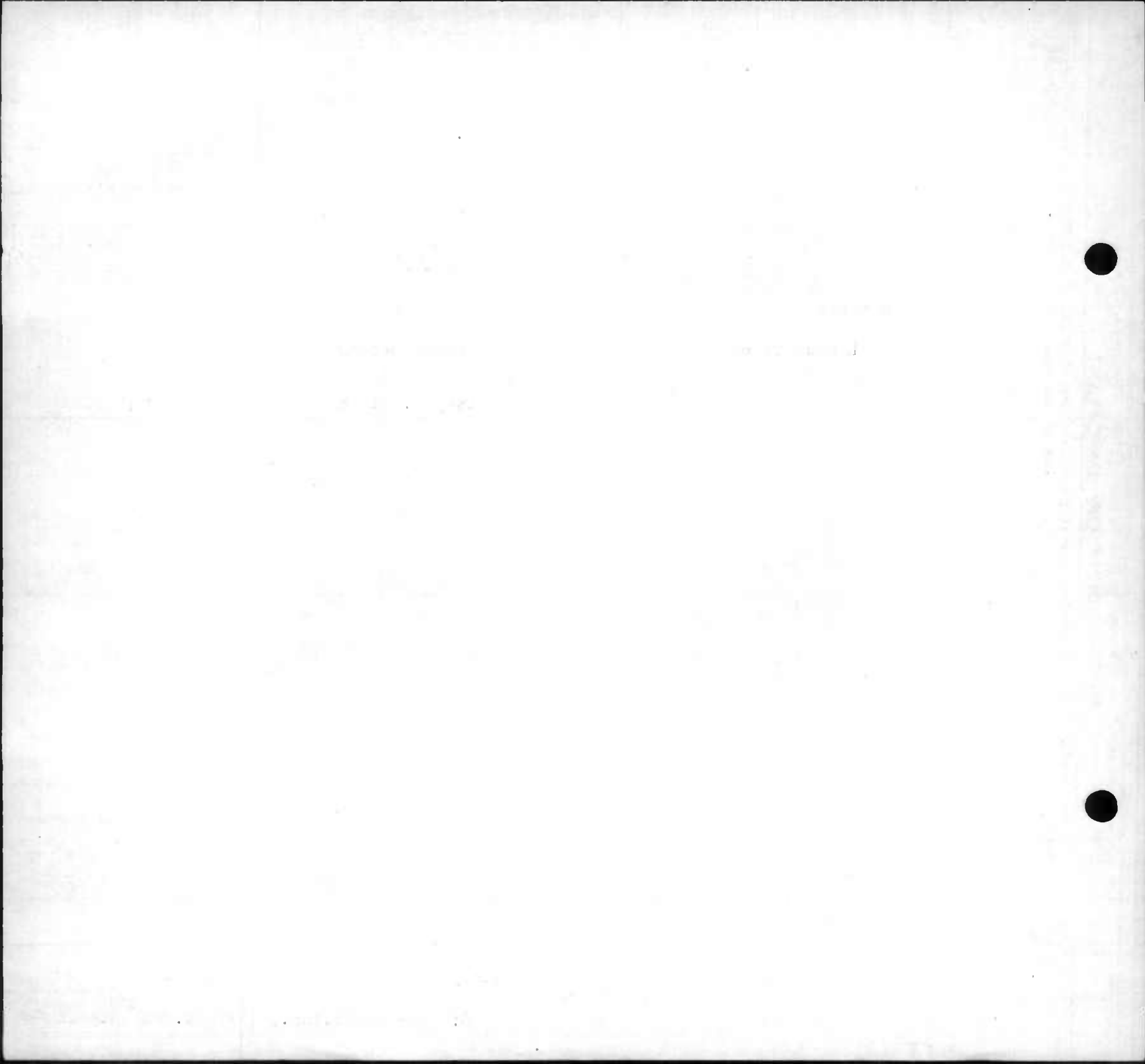
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 65 4637		Registered No. 65 4637							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Charles Edward Prophet				2. DATE AND HOUR OF DEATH 4-27-65 1:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital						A. STATE Md.			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 3200			
						D. STREET ADDRESS (If rural, give location) 113 Hammonds Lane			
5. SEX Male	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 9/17/13	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service Worker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richmond Prophet						14. MOTHER'S MAIDEN NAME Virginia Ward			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 261-03-3701		17. INFORMANT Robert E. Stoner		ADDRESS University Hospital Baltimore	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Malignant Pulmonary Effusion						INTERVAL BETWEEN ONSET AND DEATH 2 months			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) Malignant Pulmonary Effusion (B) Alveolar cell carcinoma (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/27/65 to 4/27/65, that (I) (we) last saw the deceased alive on 4/27/65 and that is (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Robert E. Stoner MD						M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/27/65	
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner						23D. ADDRESS University Hospital Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-1-65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 30 1965			25B. NAME OF REGISTRAR Robert E. Stoner			25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc., 1217 St. Paul St., 21202		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4638</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4638</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Effie T. Goodman</i>		2. DATE AND HOUR OF DEATH <i>April 29/65</i> <span style="float: right;"><i>5:07 PM</i></span> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Simai Hospital of Baltimore Inc.</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Wicomico</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4218 Falls Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/7/81</i>	9. AGE (In years last birthday) <i>83 yr.</i>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Trader</i>				14. MOTHER'S MAIDEN NAME <i>Laura Seegar</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Harvey E. Stoner, 215 Preston Court, 21228</i>			
18. <i>151X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Renal failure</i> DUE TO (B) <i>Dehydration &amp; rickets</i> DUE TO (C) <i>Upper GI obstruction 20 to 25 ft of gastric fundus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 - 2 days</i> <i>3 weeks or more</i> <i>6 mos. 6 (postop)</i>	
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>ASCVD w/ RBBB</i> <i>Pneumonia w/ pleural effusion</i>			
19A. DATE OF OPERATION <i>Nov. 84</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Partial gastrectomy w/ Roux-Y anastomosis</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 3</i> 19 <i>65</i> to <i>April 29</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>April 29</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Eric H. Bernas</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>April 29/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. H. Bernas</i>		23D. ADDRESS M.D. <i>Wm. Cook-Brooks, Inc., 1217 St. Paul Street</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-1-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 30 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks, Inc., 1217 St. Paul Street</i>			

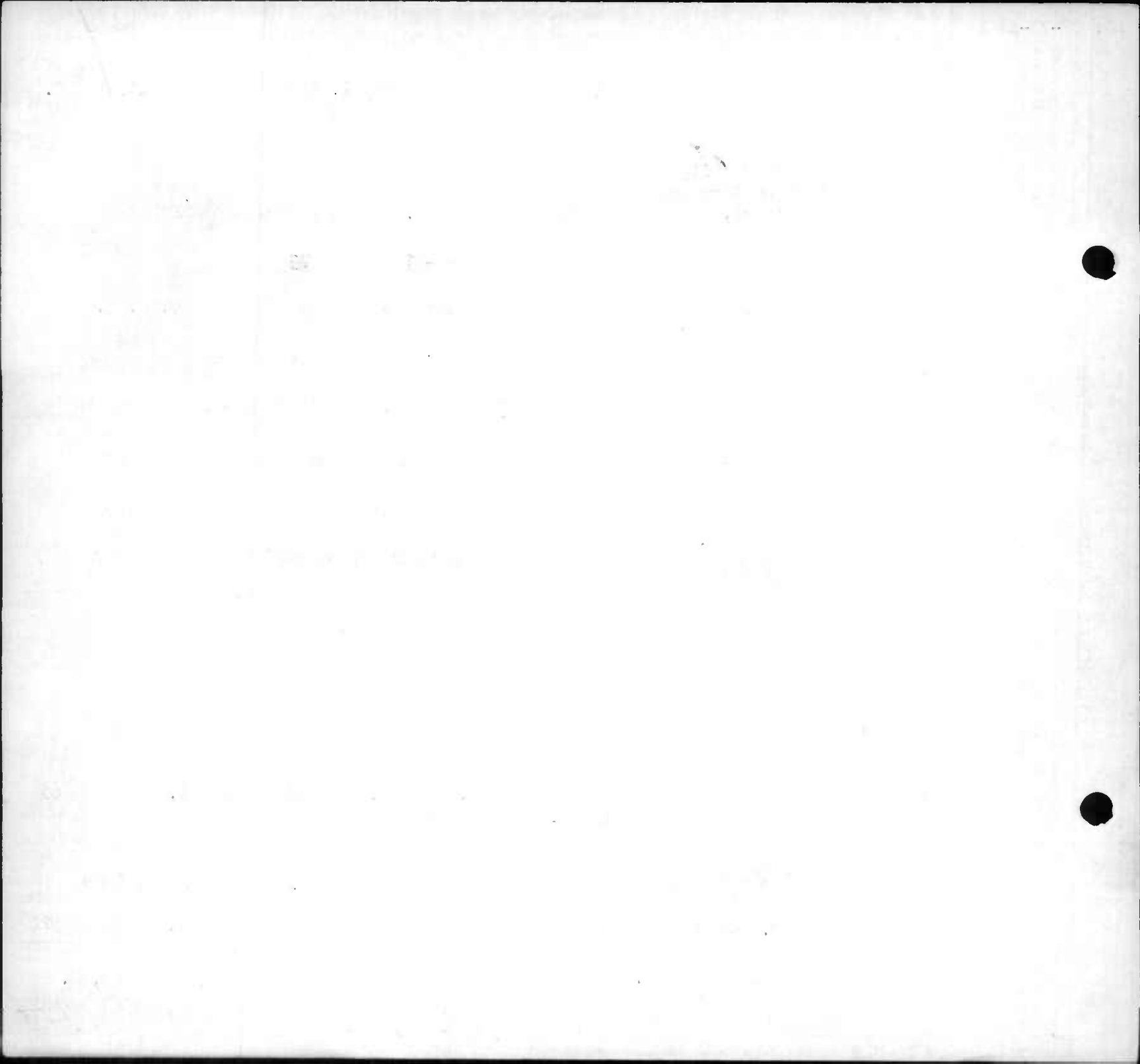


IS: 39-78-41

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 4639		CERTIFICATE OF DEATH		65 4639	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)			
		Roae Buczkowski			
2. DATE AND HOUR OF DEATH		May 1, 1965 11:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location)		Maryland			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location)		610 S. Bradford Street #21224			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	White	Widowed	6-2-91	73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
FOOD PACKING		PACKING HOUSE		Maryland	
12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
John Piskor		Eva Sobus			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		222-05-5367		RECORDS: BCH: 4940 Eastern Avenue #24	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Pulmonary Edema 1 Day	
ANTECEDENT CAUSES		(B) DUE TO		Heart Failure 7 Days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Chronic Pyelonephritis 6 Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Osteoarthritis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 5, 1964 to May 1, 1965, that (I) (we) last saw the deceased alive on May 1, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Dr. Howard Rathbun		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		May 1, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Howard Rathbun		M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/5/65		St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State)		6515 Boston St., Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 3 1965		Robert E. Fairbank		George G. Weber 705 S Ann St	



BIRTH NO.

65

4640

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

4640

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ROSA

E

HOCH

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965

2:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED 5-13-65

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6604 6116 Belair Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5/19/89

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Bohne

14. MOTHER'S MAIDEN NAME

Boemer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

218-40-6866

17. INFORMANT

ADDRESS

Katherine Winterstein

731 S. Marlyn  
Balto. 21

18.

E902.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Thrombosis of left femoral vein  
DUE TO(C) Due to fracture of left tibia and  
fibula

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

731 S. Marlyn Ave.

21D. TIME OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 19 65 1:50P.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fall from porch roof  
Jumped from porch roof

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4/29/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/3/65

23C. NAME of CEMETERY or CREMATORY

Parkwood

23D. LOCATION

(City, town, or county)

Balto.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

R. E. F. F. F.

24C. FUNERAL DIRECTOR

Grinnell

ADDRESS

300 Mace Ave. Balto. 21

WALLER J. J. J. J. J.

4/1/65  
Bill

Paula

Mr. J. J. J. J. J.

1

Paula

Bill



42-80-08 1M

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 4641

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Jeanette Floyd

2. DATE AND HOUR OF DEATH

4-25-65

9:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1621 Riggs Avenue #21217

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

6-3-1907

9. AGE (In years  
last birthday)

57

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

GEORGE CHEELEY

14. MOTHER'S MAIDEN NAME

MATLADIA GROSS

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 165-31

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Metastatic Adenocarcinoma of  
DUE TO Sigmoid Colon

3 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-7-19 65 to 4-25-19 65,  
that (I) (we) last saw the deceased alive on 4-25-19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-25-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Richard Lane

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

4-30-65

24C. NAME OF CEMETERY or CREMATORY

New Cathedral Cent.

24D. LOCATION

BALTIMORE

(City, town, or county)

(State)

MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

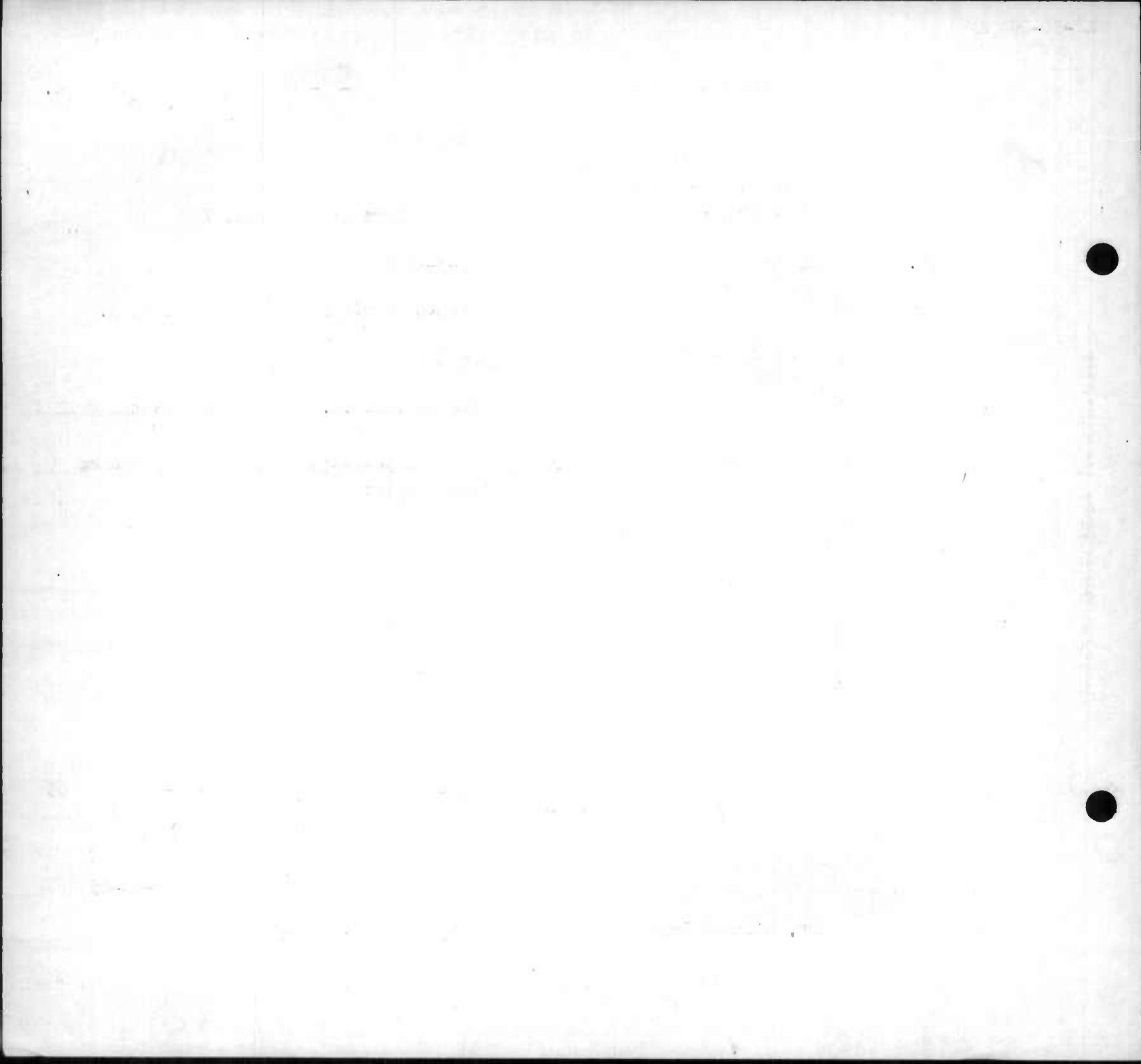
Catherine V. Cooper

ADDRESS

510 CARROLLTON AVE

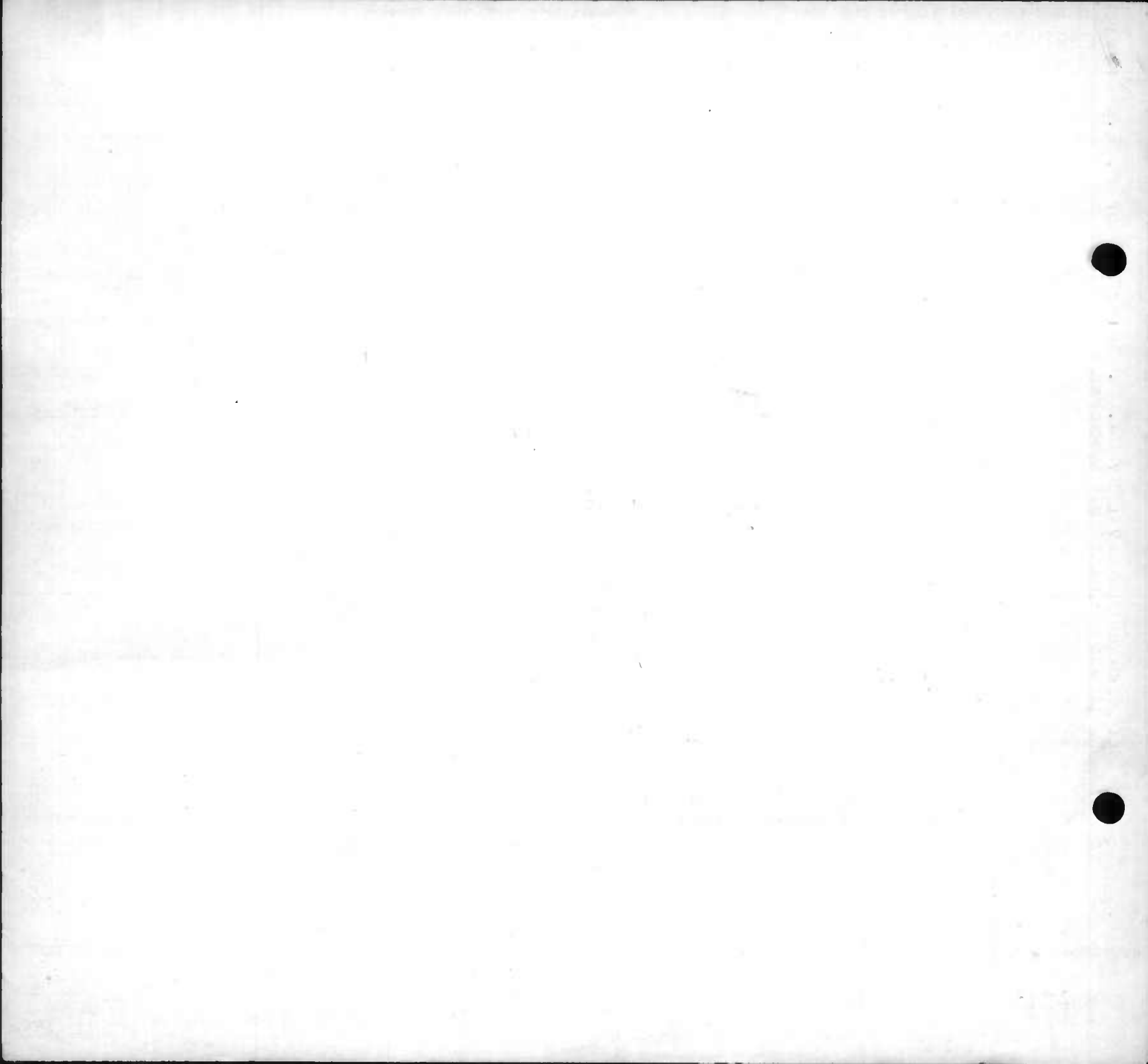
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4642				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4642	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Allen Taylor				April 29, 1965 4:00 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital				A. STATE Maryland B. COUNTY 19-02			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 17 N. Gilmore St. #23			
5. SEX M	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH DEC 23, 1891	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME CATHERINE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give word of service) YES WWI				16. SOCIAL SECURITY NO. 218-01-5767		17. INFORMANT REITA B. TAYLOR - 700 N. Gilmore St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 45-IX I Dissecting aneurysm c intra-operative hemorrhage				CAUSE OF DEATH A. DUE TO B. DUE TO C. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. unknown	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 1 4/29/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting aortic aneurysm		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/27/65 19 to 4/29/65 19, that (I) (we) last saw the deceased alive on April 29, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J.B. Peacock				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 29, 1965	
23C. PHYSICIAN'S NAME (Type) J.B. PEACOCK				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/3/65		24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL CEM.		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR HERBERT E. NUTTEN		ADDRESS 3035 W. North Ave	



BIRTH NO.

65 4643

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4643

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SUSAN POWELL

2. DATE AND HOUR PRONOUNCED DEAD

4/29/65 7:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1807 W. Lexington St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Dec 6, 1895

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Laundry

11. BIRTHPLACE (State or foreign country)

Northumberland Co, Va

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

George R. Carter

14. MOTHER'S MAIDEN NAME

Tebiedo Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Clarence C. Jones

ADDRESS

3045 Seamon Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)Hypertensive and arteriosclerotic cardio-  
vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Metastatic cancer of left breast

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type) W.U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/3/65

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert E. Parker, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Hutter 3035 W. North AVE

ADDRESS

# WALLLEY FORD

ROAD SCOUT

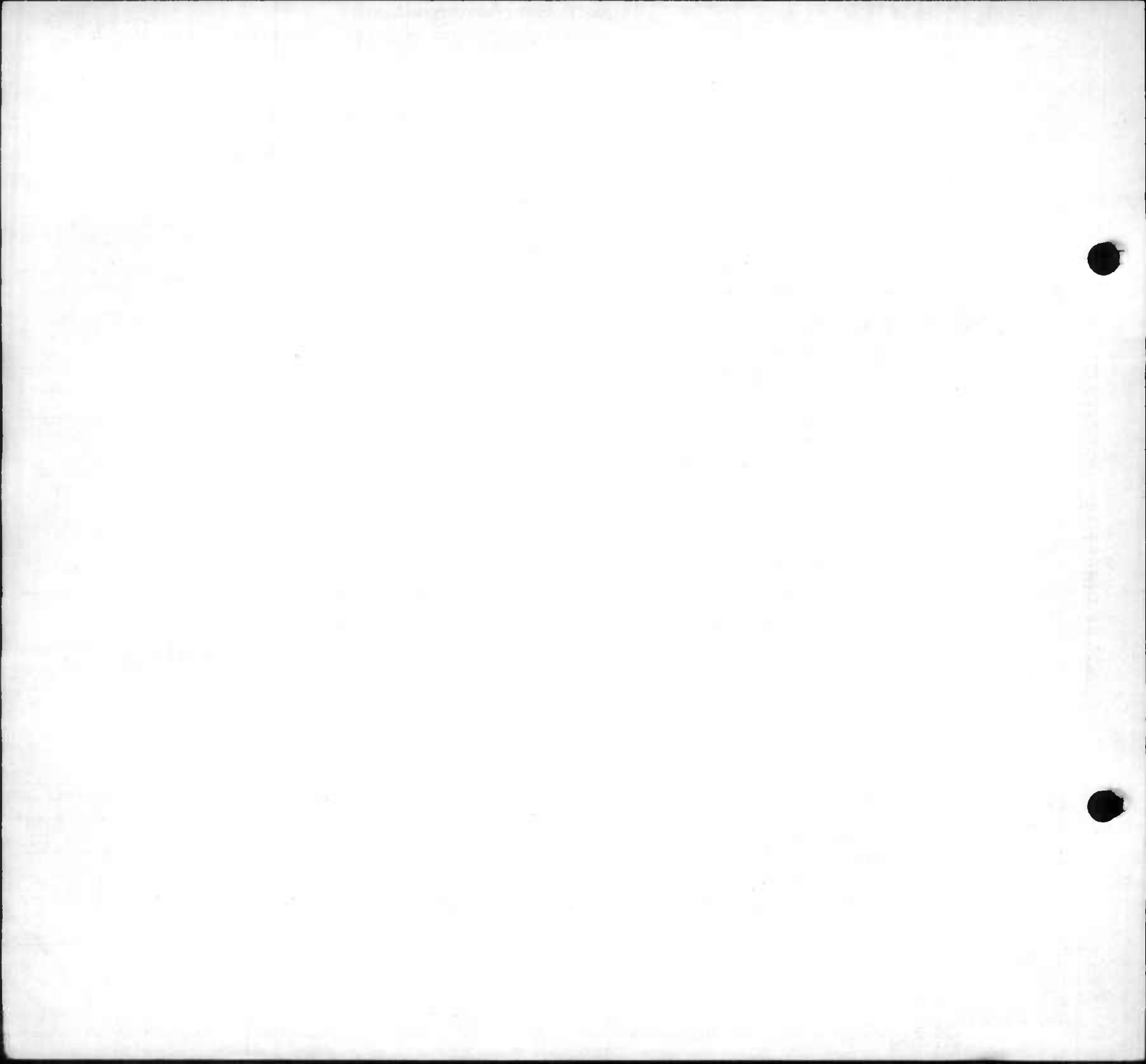
U.S.N.

WALLLEY FORD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital; (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

64- 32053		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 4644</u>	
BIRTH NO. <u>65 4644</u>		CERTIFICATE OF DEATH			
M.E. CASE NO. <u>65 4644</u>					
1. NAME OF DECEASED (Type or Print) <u>KIM Y. JOHNSON</u>			2. DATE AND HOUR OF DEATH <u>29 APR 65</u> <u>1:15 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital Baltimore</u>			A. STATE <u>Maryland</u> B. COUNTY <u>14-03</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>1816 MCCULLOH ST.</u>		
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>14 NOV 1964</u>	9. AGE (In years last birthday) <u>5 1/2</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>5 1/2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>
13. FATHER'S NAME <u>W.R. JOHNSON</u>			14. MOTHER'S MAIDEN NAME <u>TAYLOR, MARY ELIZABETH</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT ADDRESS <u>HOSPITAL RECORD (UNIV. HOSP.)</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>772.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEVERE MALNUTRITION</u> <u>GROWTH FAILURE</u> <u>CONGENITAL</u>		CAUSE OF DEATH <u>UNKNOWN CAUSES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 mo</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>SEPTICEMIA</u>					
19A. DATE OF OPERATION <u>2 NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from <u>28 Apr 1965</u> to <u>29 Apr 1965</u> , that (2) (we) last saw the deceased alive on <u>29 Apr 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Russell John Bunni Jr.</u>				23B. DATE SIGNED <u>29 Apr 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUSSELL JOHN BUNNI JR.</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL BALT. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-1-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>BALTO</u>		24E. (City, town, or county) <u>Md.</u>		24F. (State) <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR <u>Morton Dyett</u>	
25D. ADDRESS <u>1701 Laurens St.</u>					

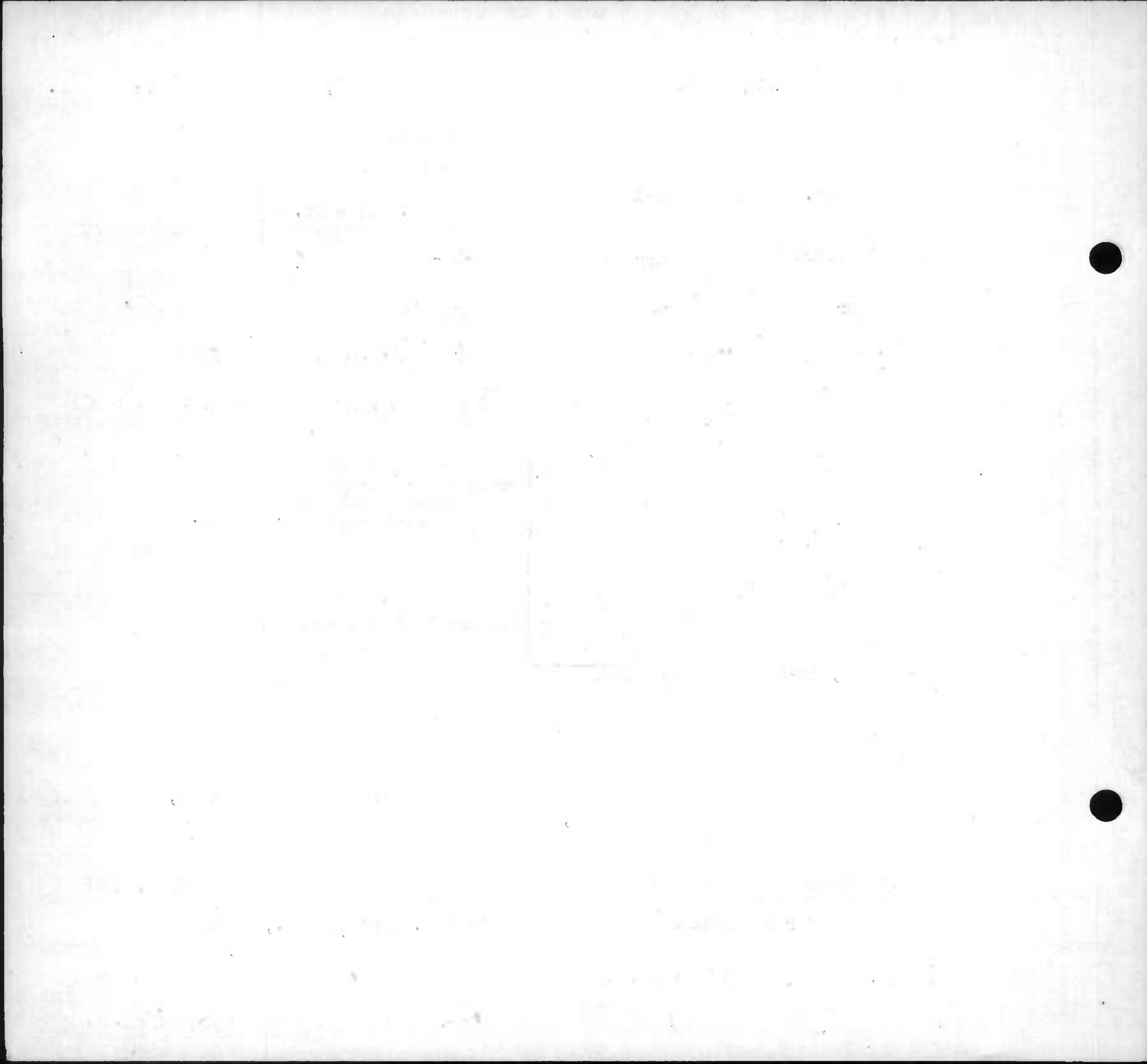




## FUNERAL DIRECTOR: IMPORTANT

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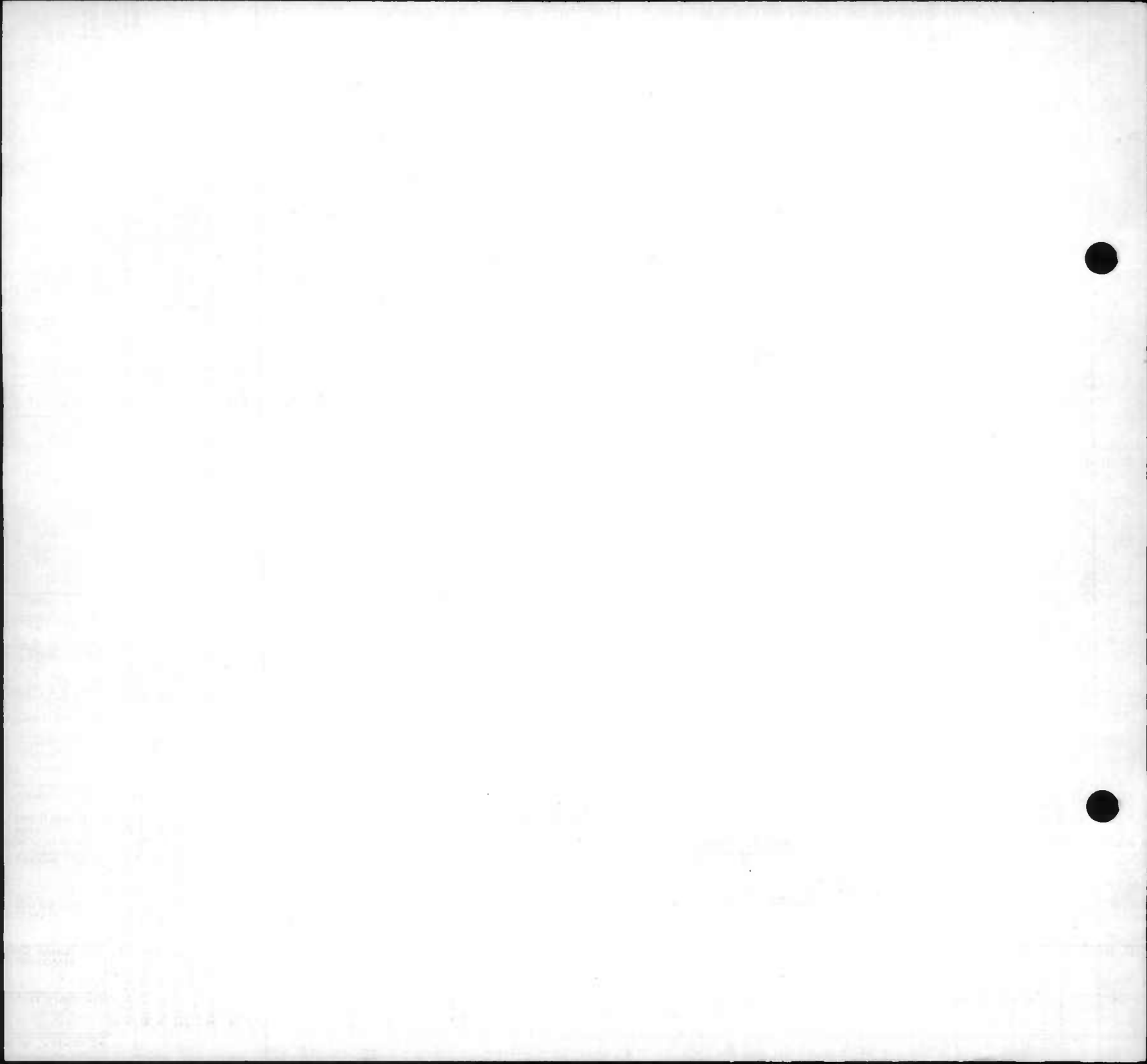
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				CERTIFICATE OF DEATH		65 4645	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Dade, Annie				May 1, 1965		7:35 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
St. Joseph Hospital				Maryland		8-06	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore #13			
				D. STREET ADDRESS (If rural, give location)			
				1506 N. Wolfe St.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
Female	Negro	Married	6-13-04	60			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker		Home		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Frank Hayes				Elizabeth Hyde			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				James Dade		1506 N. Wolfe St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				19. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				Postoperative shock following exploration for abdominal tumor causing bilateral hydronephrosis and hydroureter; uremia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Hypertensive cardiovascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
April 30, 1965		Abdominal tumor		No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from April 12, 19 65 to May 1, 19 65, that (I) (we) last saw the deceased alive on May 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Herman Boston						May 1, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Herman Boston				M.D. 1400 N. Caroline St., 21213			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5-5-65		Arbutus		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 3 1965		Robert E. Farley, M.D.		Morton J. Dyett		1701 Laurens	



# FUNERAL DIRECTOR: IMPORTANT

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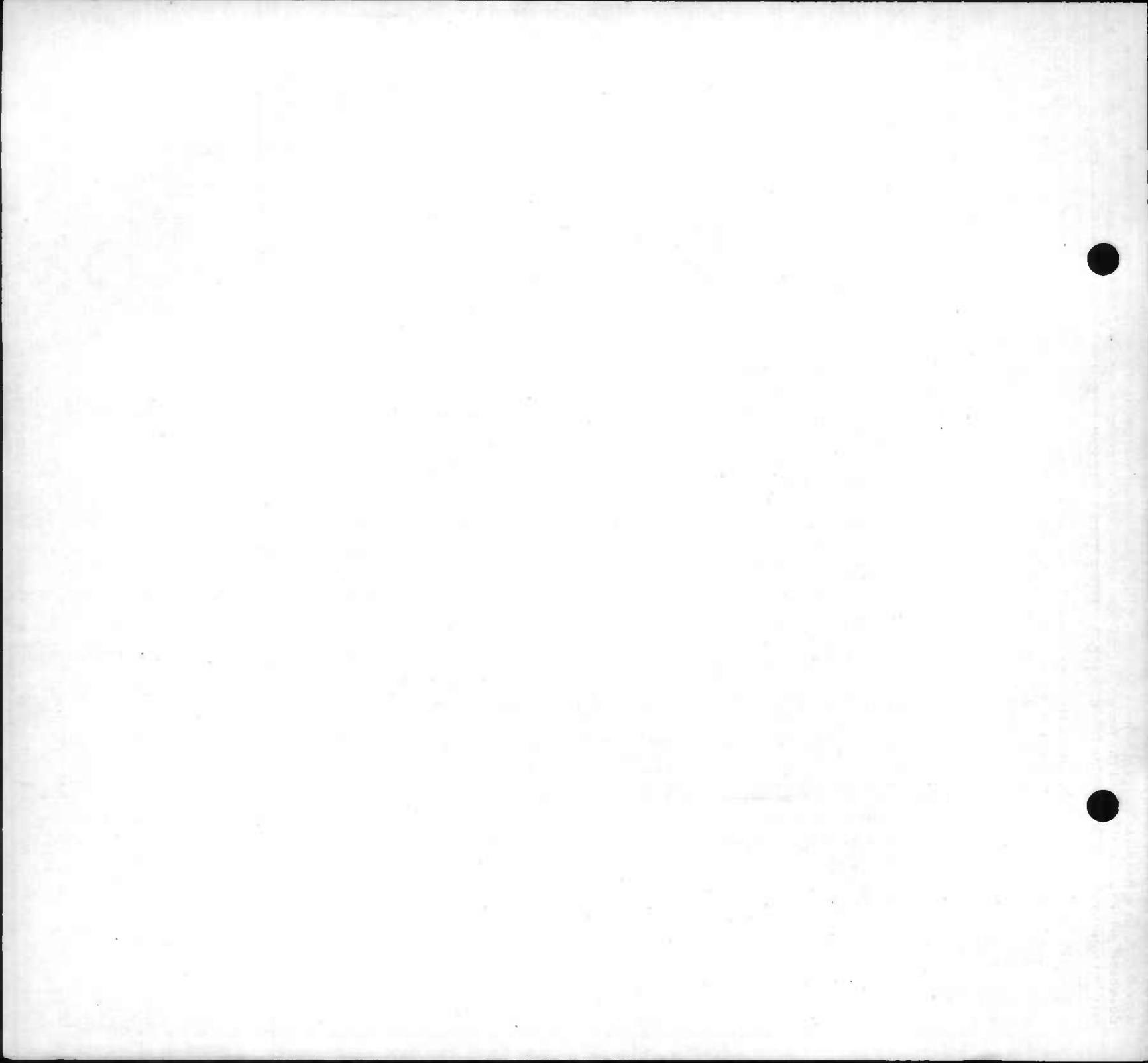
BIRTH NO. 65 4646				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4646	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				WINFIELD S ANGELMIER		April 30, 1965 11:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
				1906 Federal St		Maryland 8-06			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
						Baltimore			
						D. STREET ADDRESS (If rural, give location)			
						1906 Federal St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Male	White	Married	July 26, 1880	84					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Brace maker			Orthopedic		Baltimore Md		U S A		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Mathias Angelmier				Mary Smith					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No -				215-10-1185		Carrie Angelmier (wife) 1906 Fedreal St			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO				2 YEARS	
ANTECEDENT CAUSES				(B) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/27/63 19 to 4/30/65 19 that (I) (we) last saw the deceased alive on 4/30/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Benjamin B Moses M.D.				5/3/65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Benjamin B Moses				448 N Luzerne Ave					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		5/4/65		Oaklawn Cemetery		Eastern Ave Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAY 3 1965		Robert E. Jenkins		J. Melville Jenkins		2713 Kirk Ave			



# FUNERAL DIRECTOR: IMPORTANT

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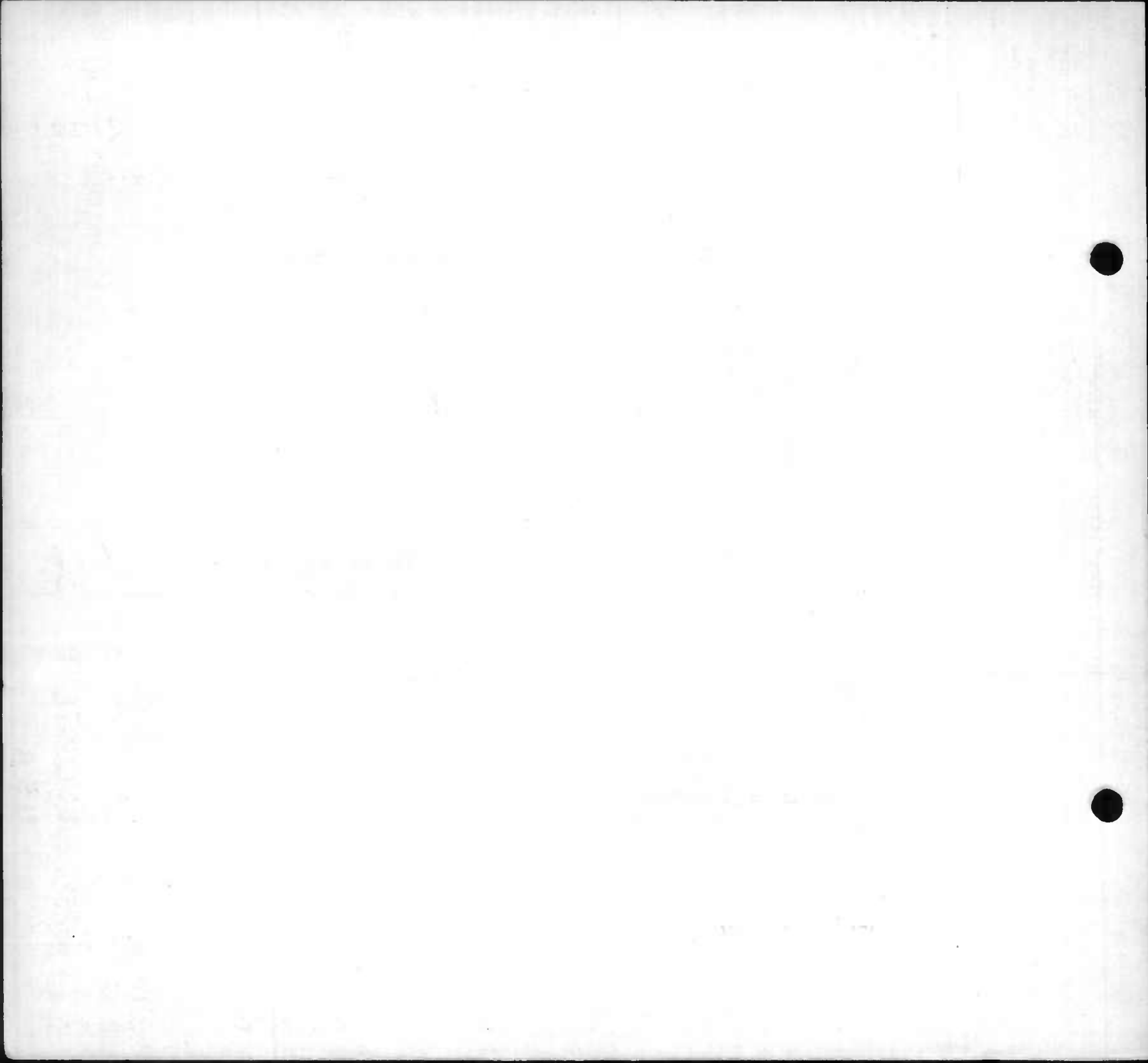
BALTIMORE CITY HEALTH DEPARTMENT									
65 4647					65 4647				
BIRTH NO.					REGISTERED NO.				
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
65 4647					Joseph V. Farace JR.				
2. DATE AND HOUR OF DEATH					May 1, 1965 1:15 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
Maryland General Hospital					Maryland 7-02				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore				
D. STREET ADDRESS (If rural, give location)					1660 Rawlworth Rd.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
M	W	Married	Dec. 31, 1925	39			Maryland	USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joseph Farace					Josephine Di Stefano				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
YES					220-12-2820				
17. INFORMANT					ADDRESS				
JOSEPH FARACE					5612 GREENHILL				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(A) Septicemia & Shock									
(B) Rheumatic Heart Disease									
(C) & Congestive Heart Failure									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
No									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from April 28 1965 to May 1 1965, that (I) (we) last saw the deceased alive on May 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
L. G. Tilley					1 May 1965				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
L. G. Tilley					Maryland General Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
BURIAL					5-4-65				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
NATIONAL CEMETERY					BALTIMORE MD				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
MAY 3 1965					Robert E. Farace				
25C. FUNERAL DIRECTOR					ADDRESS				
JOHN M. WEAVER JR					4015 CHESTER ST.				



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4648				CITY HEALTH DEPT. CERTIFICATE OF DEATH		Registered No. 65 4648	
1. NAME OF DECEASED (Type or Print) <b>FREDA ALTHAUS LOFFHAGEN</b>				2. DATE AND HOUR OF DEATH <b>4-28-65 12:35 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CATONSVILLE</b> D. STREET ADDRESS (If rural, give location) <b>2211 Pleasant Drive 5300</b>			
5. SEX <b>F</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>11-9-94</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Yr. Months: Ooys: Hours: Min.		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Jacob Althaus</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Marburger</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>William Loffhagen</b> ADDRESS <b>2211 Pleasant Dr Catonsville-28</b>		
18. <b>4-20-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial infarct</b>				CAUSE OF DEATH (A) DUE TO <b>Severe coronary sclerosis</b> (B) DUE TO <b>with occlusion of left descending coronary artery</b> (C)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Ooy) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> <b>(this hospital)</b> attended the deceased from <b>4-23-19 65</b> to <b>4-28-19 65</b> , that <b>(he)</b> <b>(we)</b> last saw the deceased alive on <b>4-28-19 65</b> and that in <b>(my)</b> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> <b>(We)</b> <b>(did)</b> <b>(did not)</b> view the body after death.							
23A. SIGNATURE <b>Rodney L. Brimhall</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-28-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RODNEY L. BRIMHALL</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/1/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LORRAINE</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>E. S. MACNABB</b>		ADDRESS <b>301 FREDERICK 21228</b>	

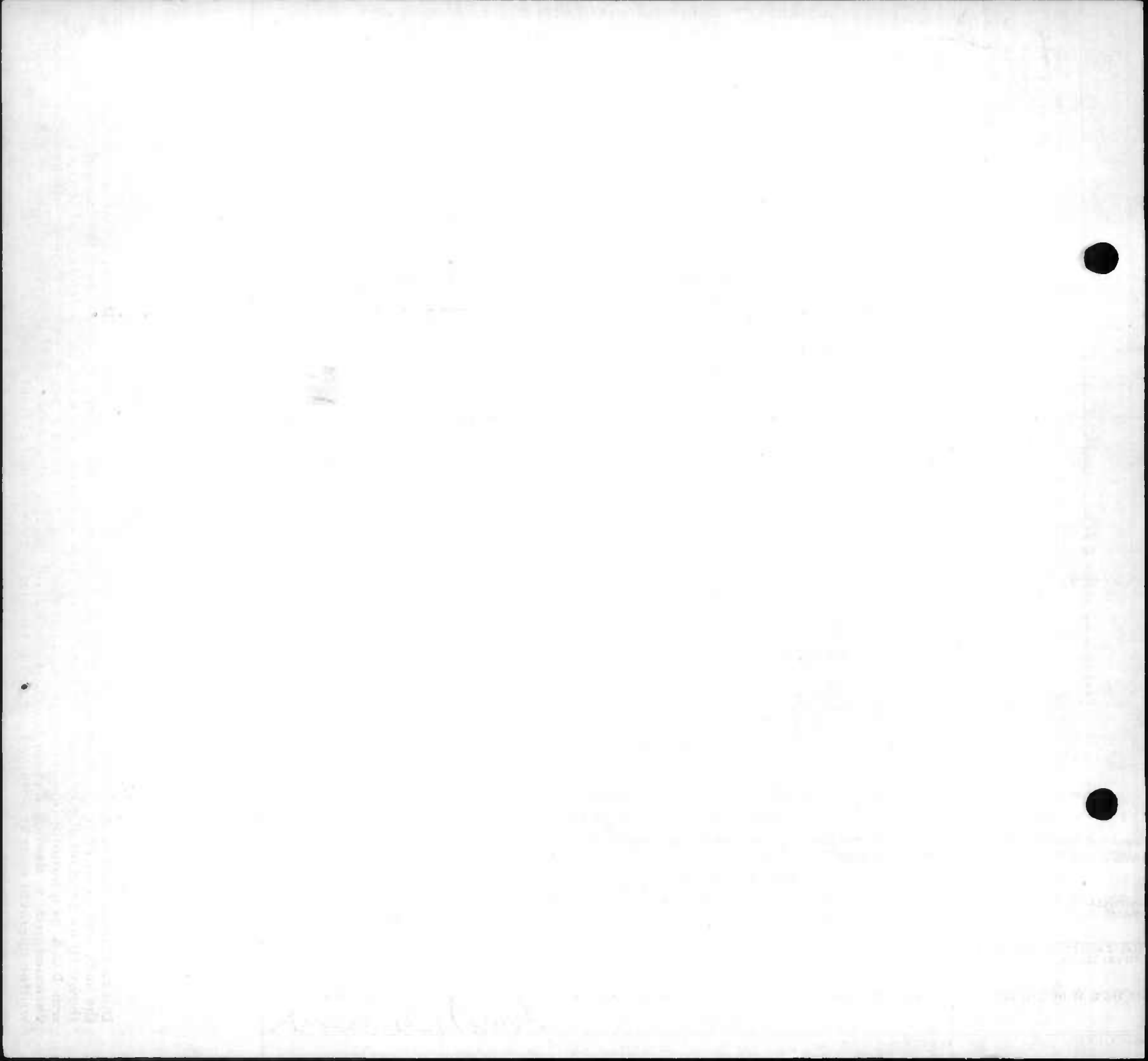




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. M.E. CASE NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4649	
1. NAME OF DECEASED (Type or Print) Rose Daudelin			2. DATE AND HOUR OF DEATH April, 30, 1965 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewis Nursing Home			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4203 Springdale Ave.		
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Oct. 22, 1875	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Virginia Lewis ADDRESS 4203 Springdale Ave. Baltimore, Md. 21207	
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebral arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 15 years		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1958 to August 30, 1965, that (I) (we) last saw the deceased alive on August 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert I. Levy				23B. DATE SIGNED 5/1/65	
23C. PHYSICIAN'S NAME (Type) Robert I. Levy				23D. ADDRESS 114 Medical Arts	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Md. 21207		24E. DATE REC'D BY HEALTH DEPT. MAY 3 1965		24F. NAME OF REGISTRAR Robert E. Talley	
24G. DATE OF REGISTRATION MAY 3 1965		24H. NAME OF REGISTRAR Robert E. Talley		24I. FUNERAL DIRECTOR Nancy M. Arundel	
24J. ADDRESS 4204 Ridgewood Ave. Baltimore, Md. 21215					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 65-0969865 4650					CERTIFICATE OF DEATH					Registered No. 65 4650						
M.E. CASE NO.										2. DATE AND HOUR OF DEATH						
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Swift</i>										4-26-65 11:25 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Church Home and Hospital</i>										A. STATE <i>MD</i> B. COUNTY <i>26-02</i>						
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>										D. STREET ADDRESS (If rural, give location) <i>5629 Frankford Ave.</i>						
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>NEVER MARRIED</i>			8. DATE OF BIRTH <i>4-24-65</i>	9. AGE (In years last birthday) <i>2 days</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John Swift</i>										14. MOTHER'S MAIDEN NAME <i>Evelyn Helen Lucas</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.		17. INFORMANT <i>5629 FRANKFORD AVE. JOHN SWIFT, BALTO. 6, MD.</i>				
18. <i>763X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES										(A) <i>bilateral bronchopneumonia - atelectasis of the right + left lower lobes; interstitial emphysema left upper lobe; pneumothorax, left</i>					<i>2 days</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) <i>10 lobes; interstitial</i>						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) <i>emphysema left upper lobe; pneumothorax, left</i>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION <i>2</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? <input checked="" type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from <i>April 24</i> 19 <i>65</i> to <i>April 26</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>April 26</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>Jose S. Maisog M.D.</i>										Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-26-65</i>				
23C. PHYSICIAN'S NAME (Type) <i>Jose S. Maisog</i>										23D. ADDRESS <i>Church Home &amp; Hospital</i>						
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>					24B. DATE <i>4-28-65</i>					24C. NAME OF CEMETERY OR CREMATORY <i>SOUTHERN</i>						
24D. LOCATION (City, town, or county) (State) <i>DUBLIN, MD.</i>					25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>						
25C. FUNERAL DIRECTOR <i>John H. Halvins</i>										ADDRESS <i>DELTA, PA.</i>						

July 1st 1960

Mr.

Dear Mr. [illegible]

20th [illegible]

4-24-60

Dear Mr.

George [illegible]

John [illegible]

Enclosed for you are  
three copies of the  
report of the [illegible]  
committee on [illegible]  
the [illegible] of the [illegible]  
and [illegible] of the [illegible]  
of the [illegible]

Yours

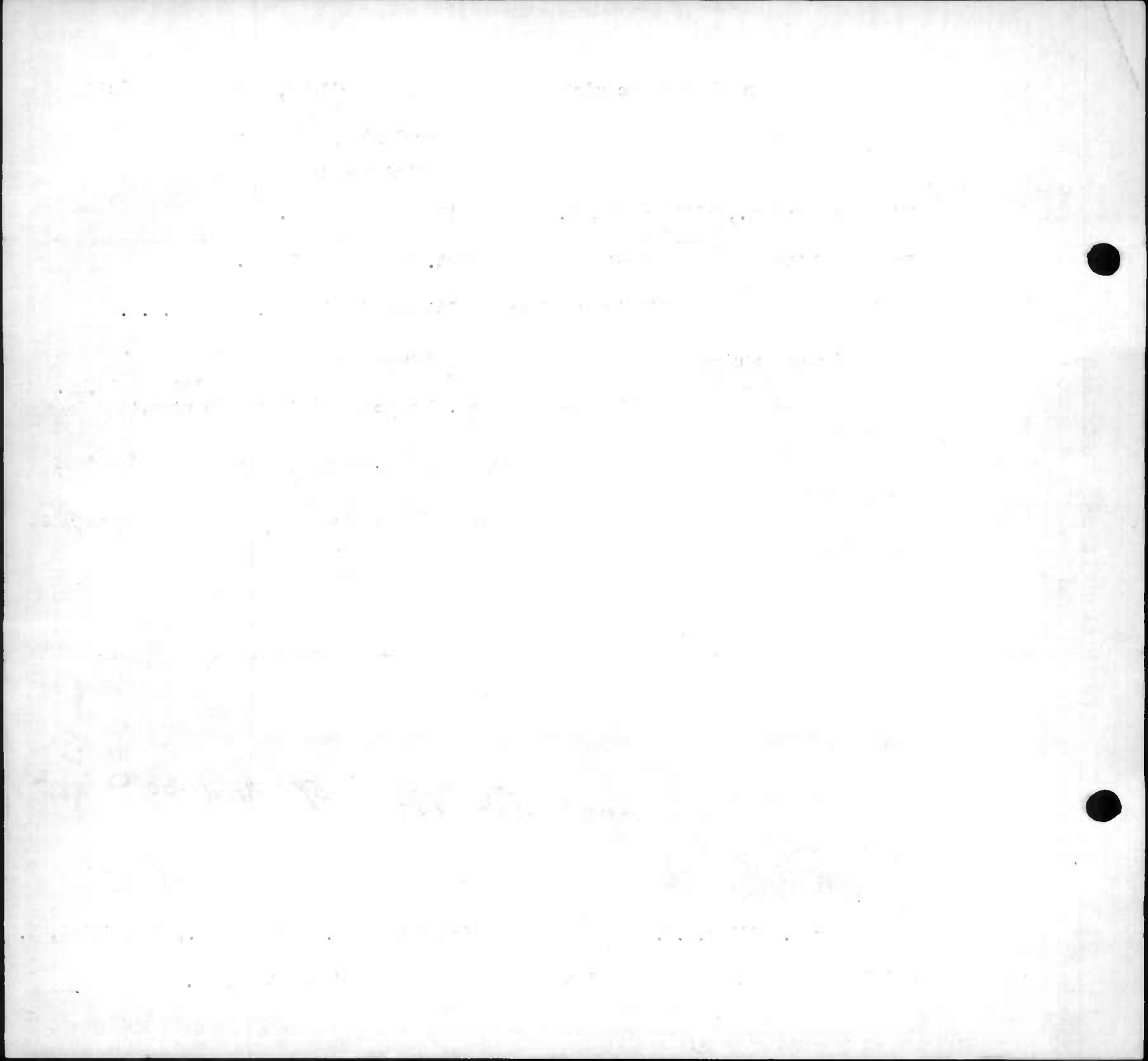
John F. Kennedy  
President of the United States

George [illegible]

FUNERAL DIRECTOR: IMPORTANT

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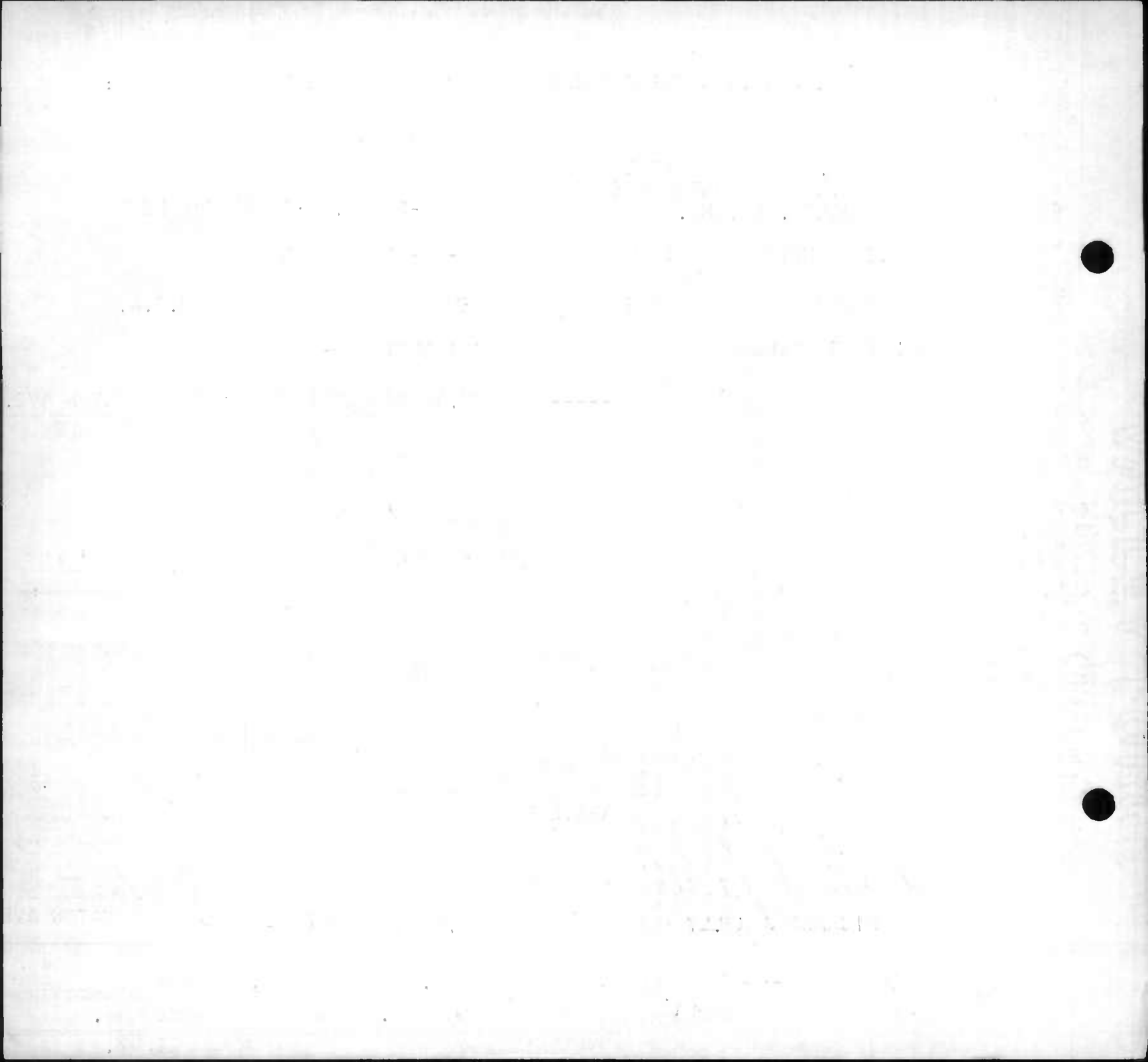
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4651</u>	
BIRTH NO. <u>65 4651</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>April 30, 1965</u> <u>1:45</u> A.M.			
1. NAME OF DECEASED (Type or Print) <u>John Joseph McGuire</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-31</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4208 Kenshaw Ave., Baltimore 15, Md.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 15</u> D. STREET ADDRESS (If rural, give location) <u>4208 Kenshaw Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 26, 1892</u>	9. AGE (In years last birthday) <u>72 yrs.</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Phillips Roofers</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Thomas McGuire</u>			14. MOTHER'S MAIDEN NAME <u>Johanna Corree</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>217-01-0295</u>	17. INFORMANT <u>Mrs. Florence Worthington McGuire, 4208 Kenshaw</u> ADDRESS <u>Baltimore 15, Md. Ave</u>		
18. <u>444X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Acute Pulmonary Edema</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours.</u> <u>18 months.</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 1954</u> to <u>April, 30th 1965</u> , that (I) (we) last saw the deceased alive on <u>April, 30th 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James A. Miller M.D.</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/1/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		23D. ADDRESS <u>Reisterstown Rd. &amp; Walker Ave., Pikesville 8, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 3, 1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Reisterstown, Md.</u>		(State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>Frank H. Newell Pikesville 8</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4652		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4652	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOWREY, MADELINE THERESA		APRIL 26, 1965		10:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD.		A. STATE MARYLAND		B. COUNTY PP	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) PASADENA		5200	
		D. STREET ADDRESS (If rural, give location) 2700-223ST. GREENHAVENFOREST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW	8. DATE OF BIRTH 12-11-02	9. AGE (In years lost birthday) 62	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ARISTADES Columbus		14. MOTHER'S MAIDEN NAME ELIZABETH ----	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -----		17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary Edema DUE TO (B) Myocardial infarction DUE TO (C) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. 3 1/2 hr. Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 25, 1965 to APRIL 26, 1965, that (I) (we) last saw the deceased alive on APRIL 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard J. Kelly		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/26/65	
23C. PHYSICIAN'S NAME (Type) RICHARD J. KELLY		23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-29-1965		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR George J. Gonce	
		25D. ADDRESS 4001 Ritchie Hwy.		Baltimore 25, Md.	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH A. ROSIPKO

2. DATE AND HOUR PRONOUNCED DEAD

4-25-65

11:08 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

14 Ballman Court

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 22, 1915

9. AGE (in years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machinist

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.

13. FATHER'S NAME

Andrew Rosipko

14. MOTHER'S MAIDEN NAME

Theresa Smelik

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

203-03-9509

17. INFORMANT

ADDRESS

Mrs. Clara L. Rosipko - 14 Ballman Ct.

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL  
SIGNATURE *Russell S. Fisher* M.D.ASSISTANT MEDICAL EXAMINER ☐

4-26-65

EXAMINER'S  
NAME (Type) RUSSELL S. FISHER, M.D.ASSOCIATE MEDICAL EXAMINER ☐23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-29-1965

23C. NAME of CEMETERY or CREMATORY

Holy Cross Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hgwy., A.A.Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

George J. Gonce

ADDRESS

4001 Ritchie Hgwy

Baltimore 25, Md.

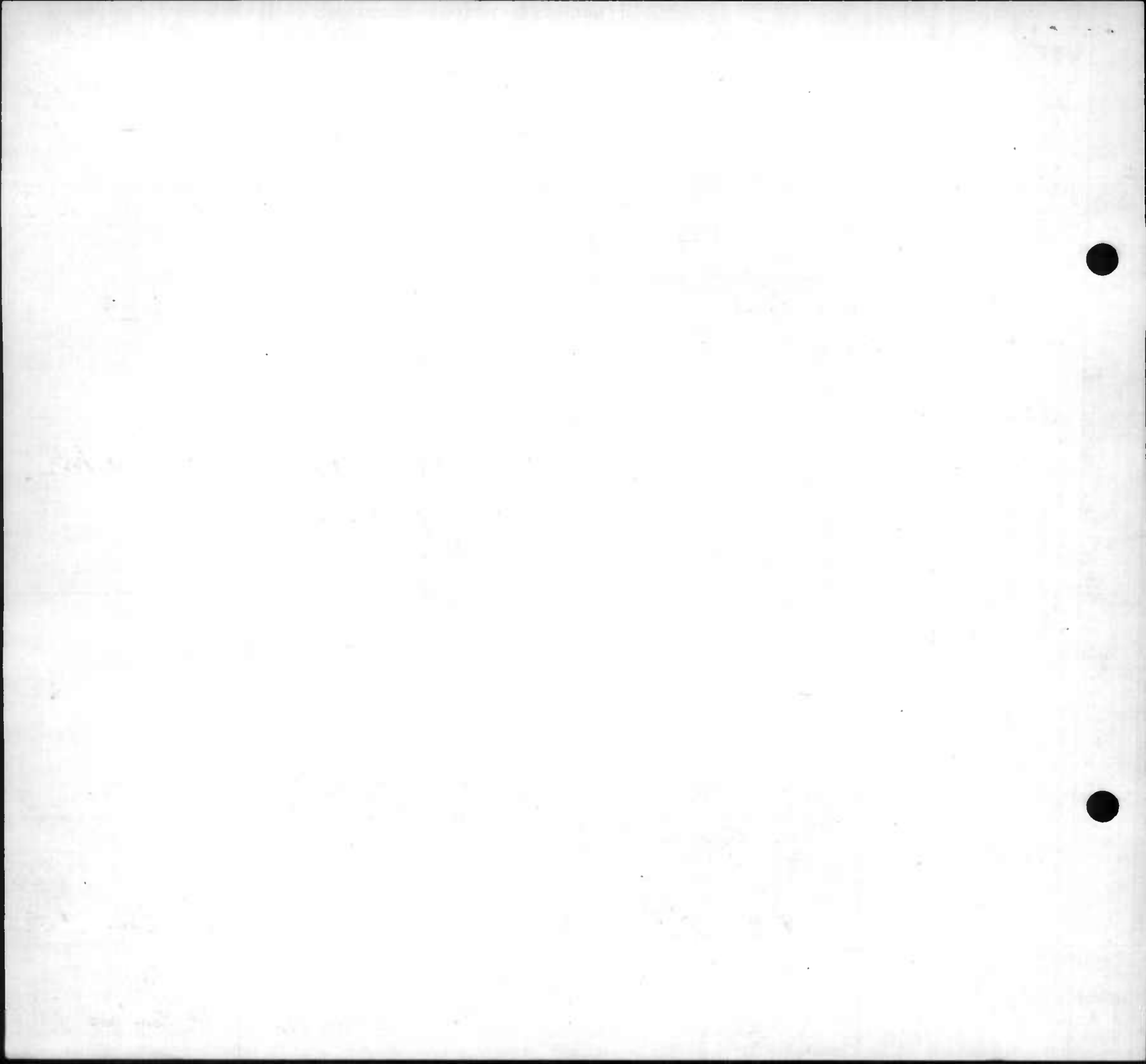
# WALLLEY FORDGE

WALLLEY FORDGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

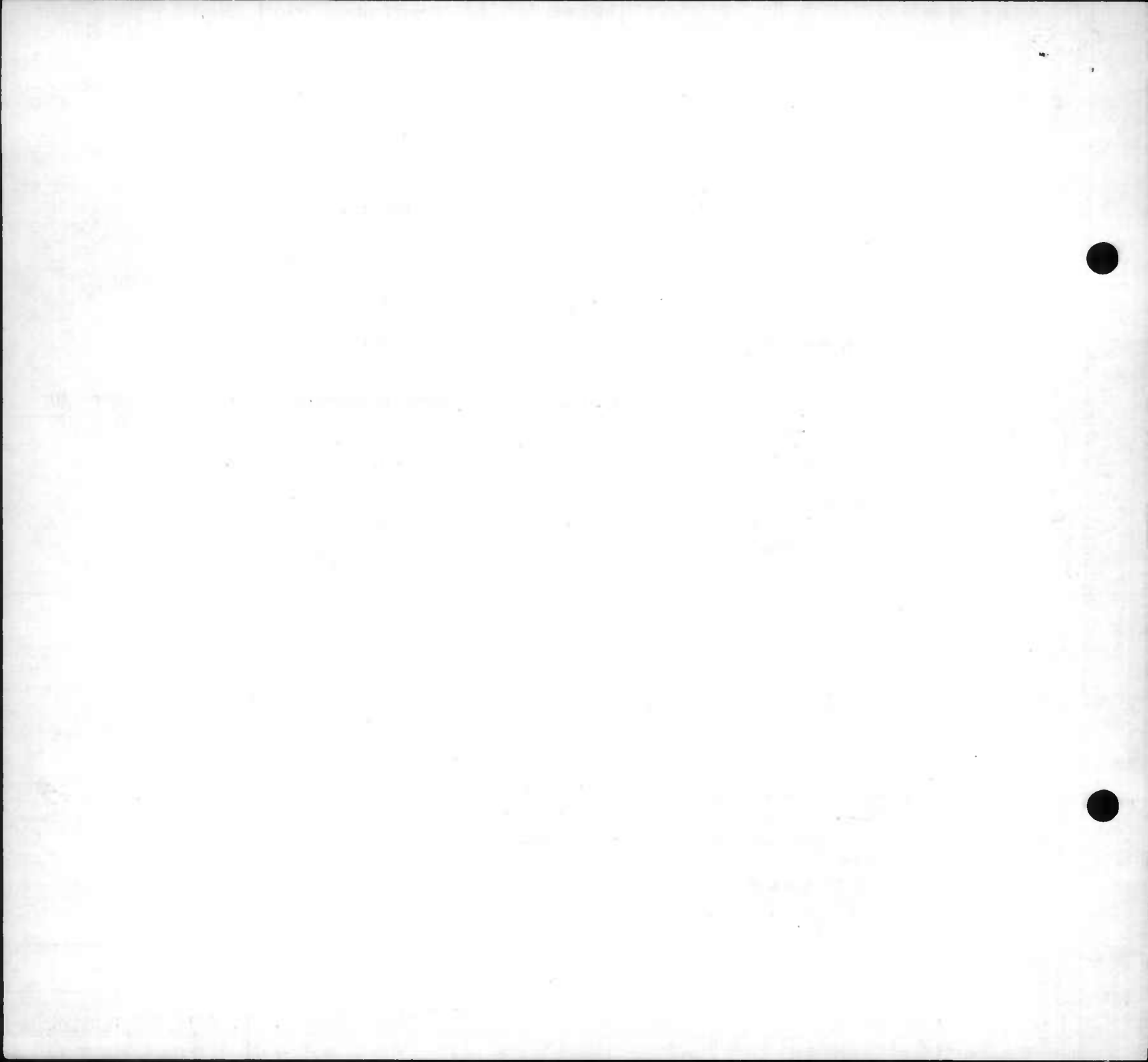
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4654				
BIRTH NO. 65 4654					1. NAME OF DECEASED (Type or Print) AUGUST ROBERT GEIWITZ				
2. DATE AND HOUR OF DEATH 4/28/65 2:15 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE					A. STATE MARYLAND B. COUNTY Balto				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53rd				
					D. STREET ADDRESS (If rural, give location) 3214 WILLOUGHBY RD				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10/21/04	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HANS GEIWITZ					14. MOTHER'S MAIDEN NAME LIDA SMITH				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215-09-9914		17. INFORMANT Hosp Records		ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES					(A) PULMONARY HE MORTALITY 2 hrs				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) CA OF LUNG				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/18/65 19 to 4/28 1965 that (I) (we) lost saw the deceased alive on 4/28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE PE BRION					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 4/28/65	
23C. PHYSICIAN'S NAME (Type) PE BRION					23D. ADDRESS FRANKLIN SQ. HOSP				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5-3-65		24C. NAME OF CEMETERY or CREMATORY GARDENS of Faith		24D. LOCATION (City, town, or county) Balto Co MD		
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965			25B. NAME OF REGISTRAR Robert E. Jenkins			25C. FUNERAL DIRECTOR CHAS. F. EVANS & SON 8802 Harford Rd.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

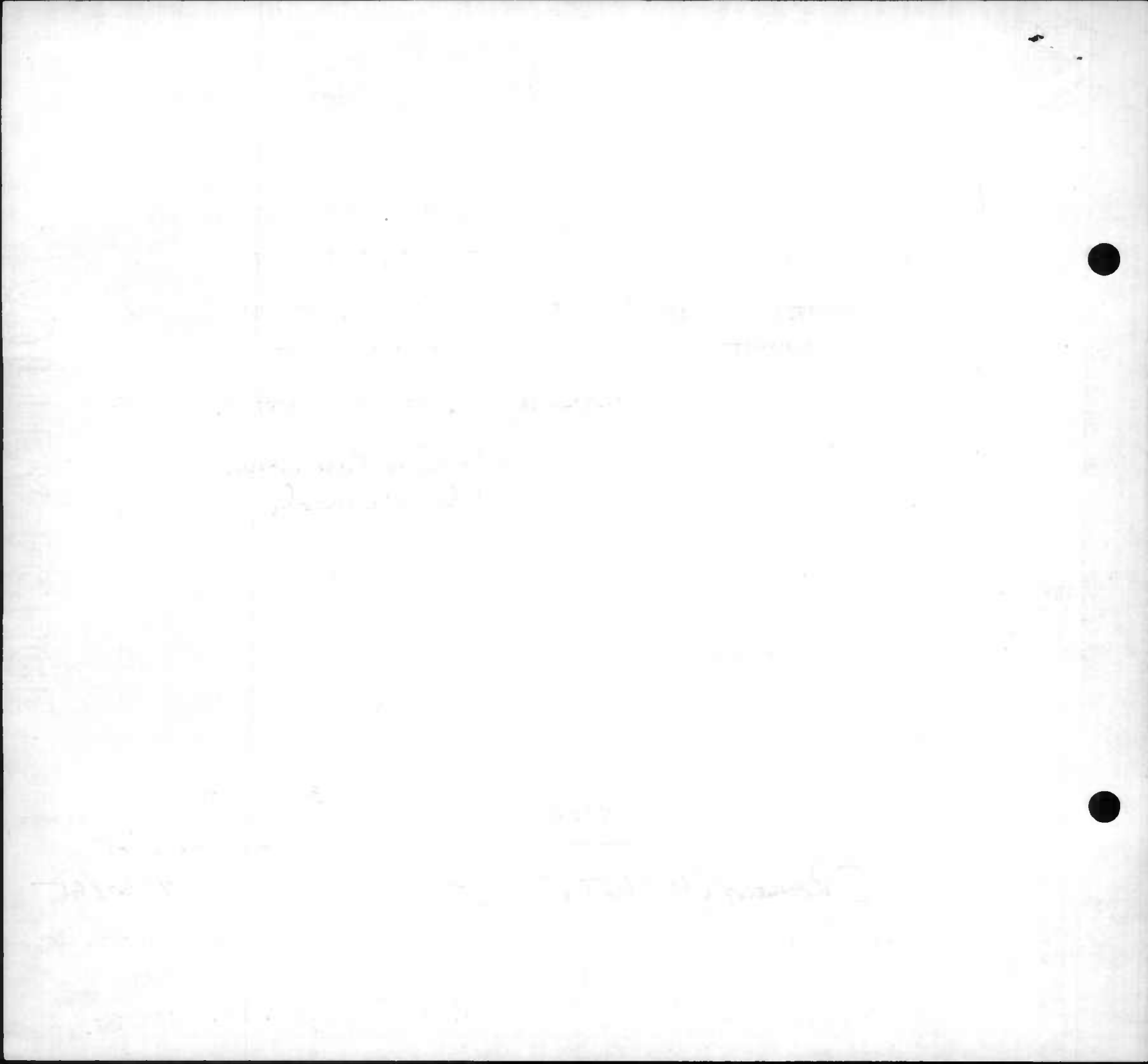
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <b>65 4656</b>				
BIRTH NO. <b>65 4656</b>					M.E. CASE NO. <b>65 4656</b>				
1. NAME OF DECEASED (Type or Print) <b>MAURICE J. FREEDMAN</b>					2. DATE AND HOUR OF DEATH <b>APRIL 28, 1965 7:20 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-20</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>4005 FORDLEIGH ROAD</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>80</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>BARNETT FREEDMAN</b>					14. MOTHER'S MAIDEN NAME <b>ESTHER ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>218-10-8280</b>		17. INFORMANT ADDRESS <b>DR. GERSHEN FREEDMAN 6700 PARK HEIGHTS AVE</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>CAUSE OF DEATH</b> (A) <b>Acute coronary Occlusion 1 min?</b> DUE TO (B) <b>Arteriosclerotic heart dis. 20 yrs?</b> DUE TO (C) <b>General arteriosclerosis 30 yrs?</b> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 min?</b> <b>20 yrs?</b> <b>30 yrs?</b>									
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b> <b>None</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1953</b> to <b>4/28 1965</b> that (I) (we) last saw the deceased alive on <b>12/16 1964</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <b>Seen in Sinai Accident Room</b>									
23A. SIGNATURE <b>Jonas Cohen</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>2/29/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>DR. JONAS COHEN</b>					23D. ADDRESS <b>6702 PARK HEIGHTS AVENUE</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/30/65</b>		24C. NAME of CEMETERY or CREMATORY <b>BALTIMORE HEBREW</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>			25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4655</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4655</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Emanuel A. Hyman</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 30, 1965</span> <span style="float: right;">3:05 P.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">3501 St Paul St Marylander Apts apt 837</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3501 ST. PAUL STREET APT 837</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">OCTOBER 19, 1894</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">UNDERWRITER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">LIFE INSURANCE</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">BAR ABAMOVITZ</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CECELIA KATZ</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WW I</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-30-6546</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS. DAISY HYMAN</span>	
18. <span style="font-size: 1.2em;">15-IX I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Metastatic Carcinoma of the stomach</span>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1957</span> to <span style="font-size: 1.2em;">1965</span> and that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">4/29</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <span style="font-size: 1.2em;">3:AM 4/30/65</span>					
23A. SIGNATURE <span style="font-size: 1.2em;">Leonard M. Lister</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/30/65</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">LEONARD M. LISTER M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">7121 PARK HEIGHTS AVENUE BALTO. MD.</span>		23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.		23F. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5/2/65</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">OHEB SHALOM</span>	
24D. LOCATION <span style="font-size: 1.2em;">BALTIMORE MARYLAND</span>		24E. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 3 1965</span>		24F. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairley</span>	
24G. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON</span>		24H. ADDRESS <span style="font-size: 1.2em;">S &amp; BROS. INC. 6010 REIST. RD</span>		24I. DATE SIGNED	





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 4657</b>	
BIRTH NO. <b>65 4657</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>4-29-65 9:45am.</b>	
1. NAME OF DECEASED (Type or Print) <b>Helen J. Wolff</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital of Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>7903 MONTWOOD ROAD</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-27-16</b>
9. AGE (In years last birthday) <b>49</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ADVERTISING AGENCY</b>	
11. BIRTHPLACE (State or foreign country) <b>DAYTON, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABRAHAM SCHAEEN</b>		14. MOTHER'S MAIDEN NAME <b>REBA SCHAEEN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. WILLIAM J. WOLFF</b>		ADDRESS <b>7903 MONTWOOD ROAD</b>	
18. <b>199.2.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Undifferentiated Carcinoma, etiology unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 2 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from <b>3-8</b> 19 <b>65</b> to <b>4-29</b> 19 <b>65</b> , that (I) <del>was</del> last saw the deceased alive on <b>4-29</b> 19 <b>65</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) <del>not</del> view the body after death.			
23A. SIGNATURE <b>Harry M. Charkatz</b>			23B. DATE SIGNED <b>4-29-65</b>
23C. PHYSICIAN'S NAME (Type) <b>Harry M. Charkatz</b>			23D. ADDRESS <b>Sinai Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>5/2/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Fink</b>	25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. INC.</b>	
ADDRESS <b>6010 REISTERSTOWN RD</b>			

2nd Hospital of Baltimore

From War Service

3-27-10

43

Metastatic Unidentified  
(Cancer, possibly melanoma)

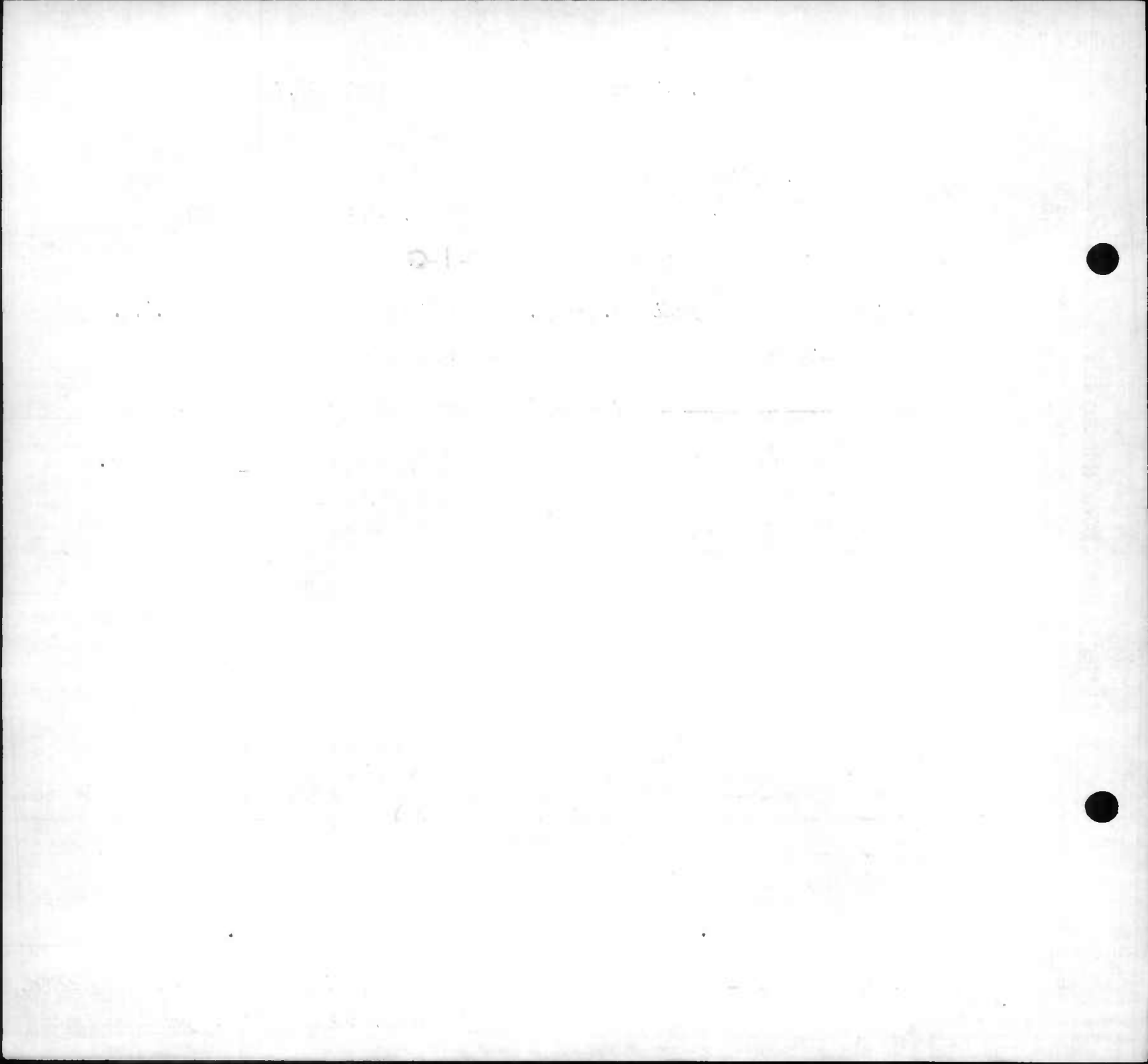
Harry M. Charles  
Harry M. Charles

2nd Mar 1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
65 4658					CERTIFICATE OF DEATH					Registered No. 65 4658				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
					John J. Zinner					2. DATE AND HOUR OF DEATH April 27, 1965 1 10:00 A. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 708 S. Robinson Street Baltimore Md. 21224										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
										D. STREET ADDRESS (If rural, give location) 708 S. Robinson Street #24				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 8-1-95		9. AGE (In years last birthday) 69		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Zinner						14. MOTHER'S MAIDEN NAME Anna Welch								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-03-4749		17. INFORMANT ADDRESS Mary Gnampp 3809 Gough Street #24								
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-vascular Disease										INTERVAL BETWEEN ONSET AND DEATH 1 yr.				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION D				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (the hospital) attended the deceased from July 19 64 to April 19 65, that (I) (we) last saw the deceased alive on April 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Clarence W. LeDoux										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) Clarence W. LeDoux						23D. ADDRESS 3023 Eastern Ave.								
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4-30-65		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery				24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Balto. 22, Md.				
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965				25B. NAME OF REGISTRAR Robert E. Farkner				25C. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler 901 S. Conkling Street						



39-35-50 AM

## BALTIMORE CITY HEALTH DEPARTMENT

65 4659

## CERTIFICATE OF DEATH

Registered No.

65 4659

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

A. Katherine Glaeser (Glaeser)

2. DATE AND HOUR OF DEATH

4-26-65

7:15 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2204 Walshire Avenue #21214

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8-19-90

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

House Work

11. BIRTHPLACE (State or foreign country)

Maryland, BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown PHILIP GRAFF

14. MOTHER'S MAIDEN NAME

Unknown LOUISE MIENER

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

13511 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Metastatic Carcinoma of the  
DUE TO Gall Bladder.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-23-19 65 to 4-26-19 65,  
that (I) (we) last saw the deceased alive on 4-26-65 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Lane

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-26-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Richard Lane

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-29-65

24C. NAME OF CEMETERY or CREMATORY

Schwartz Cemetery

24D. LOCATION

(City, town, or county)

(State)

6115 O'Donnell St. Balto 24, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

25B. NAME OF REGISTRAR

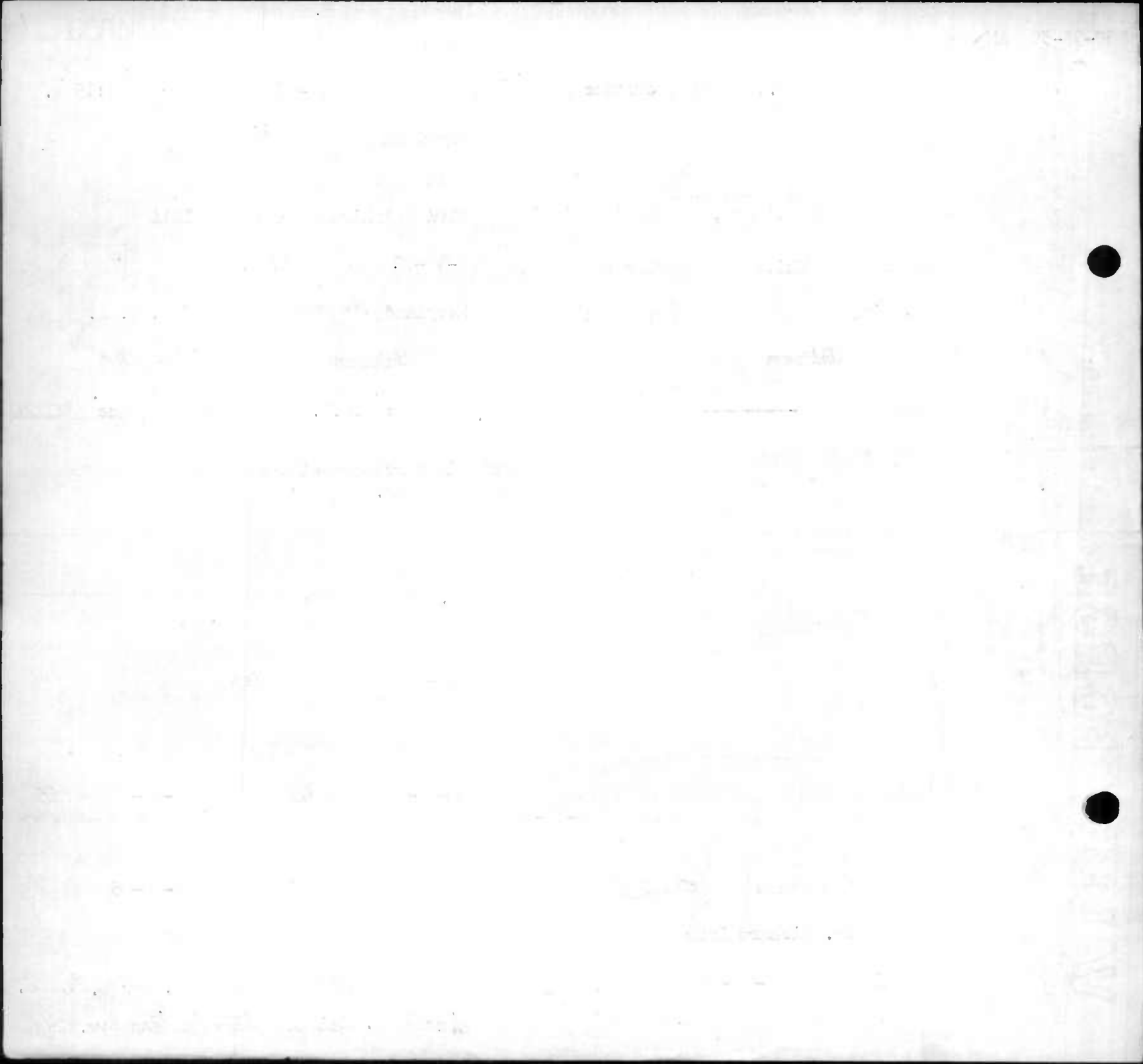
Robert E. Taylor

25C. FUNERAL DIRECTOR

Charles S. Zeiler 6224 Eastern Ave. #24

FUNERAL DIRECTOR: IMPORTANT

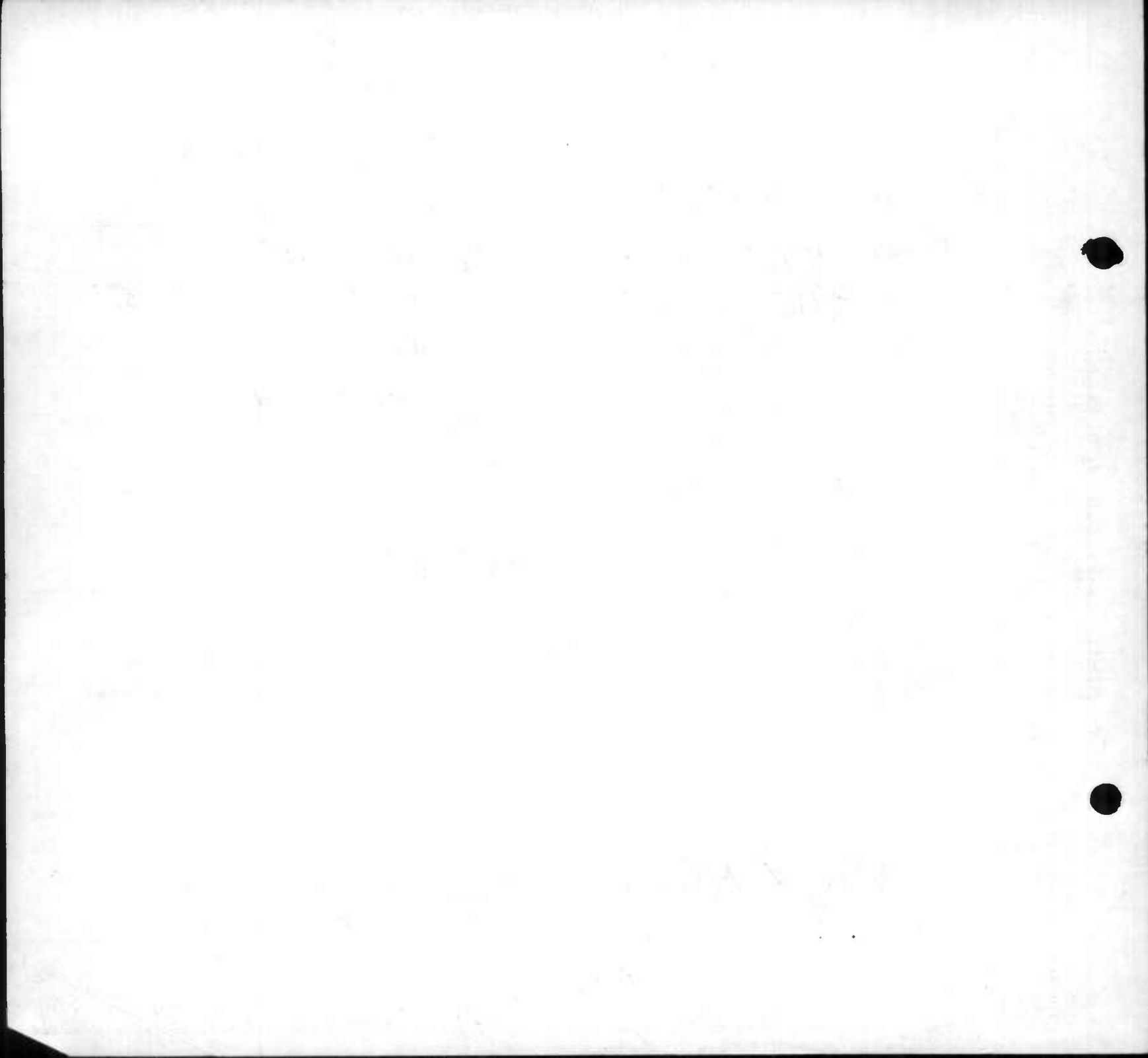
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4660		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4660	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>TURPIN, LAURA -</b>		2. DATE AND HOUR OF DEATH <b>4/28/65</b> <b>8</b> <b>p.</b> <b>M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital, Baltimore Md.</b>		A. STATE <b>Md.</b> B. COUNTY <b>Sarumet</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CRISFIELD</b>			
		D. STREET ADDRESS (If rural, give location) <b>308 Tyler St</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>May 1899</b>	9. AGE (In years last birthday) <b>65</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cran Picker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sea food.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>NED STEVENSON</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Bennet</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Sam. TURPIN</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>171X I</b> <b>Pneumonia</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Aplastic Anemia</b>			
		(C) <b>Sq Cell Carcinoma of Cervix</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>April 6, 1965</b> to <b>April 28, 1965</b> , that (1) (we) last saw the deceased alive on <b>April 28, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mary L. Klein</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>4/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mary L. Klein</b>		23D. ADDRESS <b>University Hospital, Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>CRISFIELD Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Anthony E. Ward</b>	
				ADDRESS <b>CRISFIELD Md.</b>	

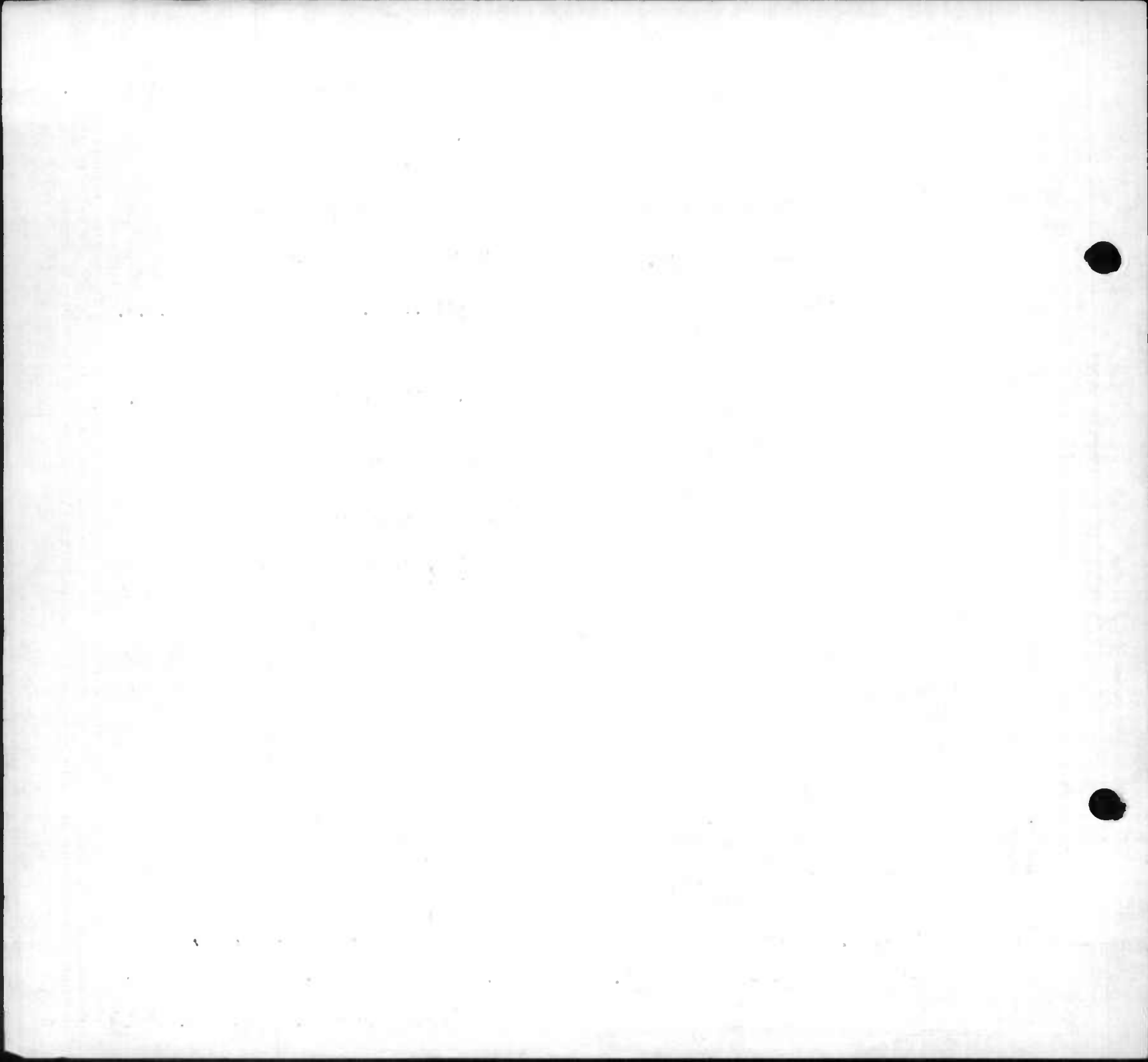




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

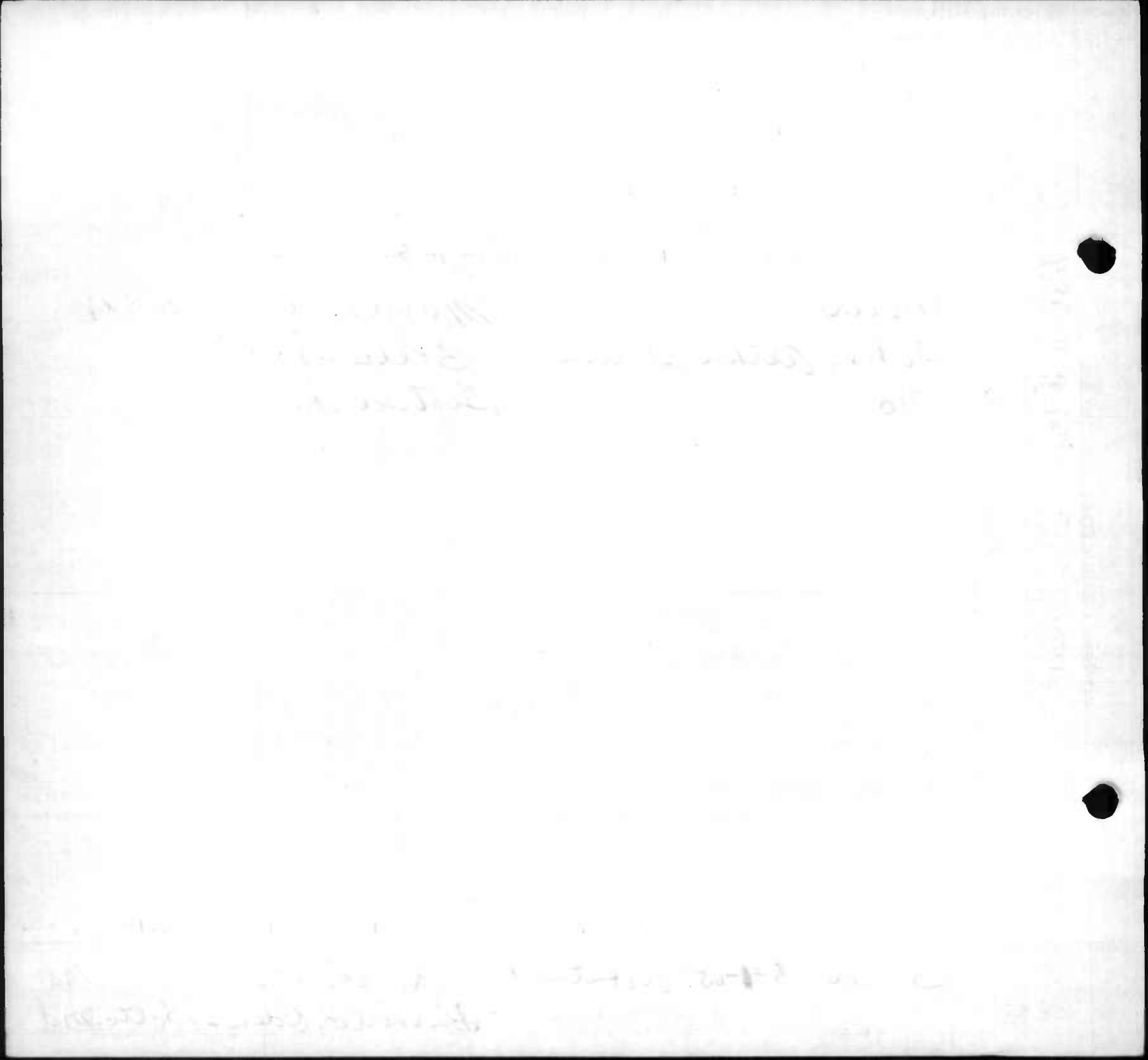
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 4661</u>	
BIRTH NO. <u>65 4661</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>SELENA REID BAILEY</u>				2. DATE AND HOUR OF DEATH <u>4-29-65</u>   <u>11:55</u> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2609 Forester Avenue</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>25-42</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2609 Forester Avenue</u>			
5. SEX <u>fe</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Wid.</u>	8. DATE OF BIRTH <u>9/28/1883</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Edith Allen 2609 Forester Ave.</u>			
18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Aged</u>				CAUSE OF DEATH (A) <u>Terminal Pneumonia</u> DUE TO (B) <u>Cerebral Vascular Accident</u> DUE TO (C) <u>Hypertensive Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lineal G. Desbordes</u> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4/30/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lionel A. Desbordes</u>				23D. ADDRESS M.D. <u>2930 Baker St. Balt. 16, Md.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Morton &amp; Dyett F. Home, Inc.</u>		ADDRESS <u>1701 Laurens</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

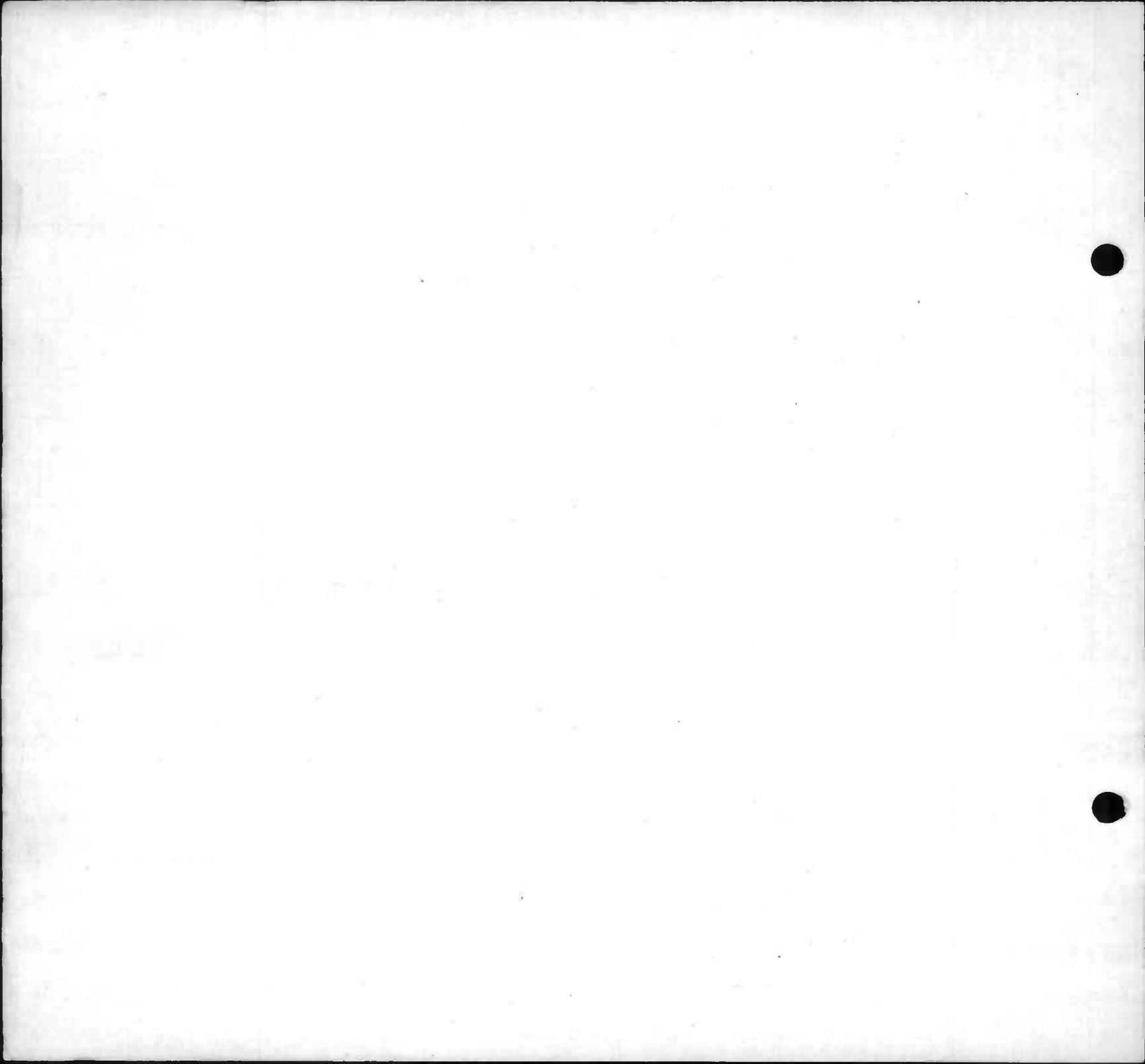
5462 65 4662		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 4662	
BIRTH NO. 65 4662 M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SOLLERS, CLEMENT</b>		2. DATE AND HOUR OF DEATH <b>4-29-65</b>   <b>3<sup>30</sup></b> P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>18-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1217 W. FAYETTE ST. ZION NURSING HOME</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>9-17-92</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mover</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Arthur Sollers</b>			14. MOTHER'S MAIDEN NAME <b>Belle Sollers</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Beatrice Sollers - 300 Gilman ST</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>CEREBROVASCULAR ACCIDENT</b> <b>2 WKS.</b> DUE TO (B) <b>ARTERIOSCLEROTIC VASCULAR</b> <b>YEARS</b> DUE TO <b>DISEASE</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>HYPOTHERMIA</b> <b>UNKNOWN ETIOLOGY</b>		<b>2 WKS.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-20-65</b> 19 <b>65</b> to <b>4-29</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-29</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Paul D. Hart</b> M.D.				23B. DATE SIGNED <b>4-29-65</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>PAUL D. HART M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-4-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pk. Arbutus Md</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>	
25C. FUNERAL DIRECTOR <b>Thurmon B. Oden - Balto. Md</b>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4663	
BIRTH NO. 65 4663											
M.E. CASE NO. ①											
1. NAME OF DECEASED (Type or Print) <b>NASH, EARL H.</b>						2. DATE AND HOUR OF DEATH <b>April 24, 1965 12<sup>50</sup> P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-03</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>					
D. STREET ADDRESS (If rural, give location) <b>2305 MONTEBELLO TERRACE</b>											
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-15-22</b>		9. AGE (In years last birthday) <b>43</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>EARL H. NASH</b>						14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<div style="writing-mode: vertical-rl; transform: rotate(180deg); position: absolute; left: 50%; top: 50%;">                     CERTIFICATION APPROVED BY  <i>John E. Bell</i>                      M.D.                      CHIEF OF ASSISTANT MEDICAL EXAMINERS                 </div>						18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Cerebral Infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>96 hours</b>	
						18. ANTECEDENT CAUSES <b>Temporary Carotid Insufficiency</b>				96 hours	
						18. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Right Common Carotid injury</b>				96 hours	
						18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>During biopsy of mediastinal mass - mediastinal collagenosis</b>				96 hours	
19A. DATE OF OPERATION <b>3 4-20-65</b>						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Right Common Carotid Injury</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Johns Hopkins Hospital 07-05</b>					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>Apr 4 20 65</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Carotid artery injury during mediastinal exploration for tumor - therapeutic misadventure</b>					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 14 19 65</b> to <b>April 24 19 65</b> and that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 24 19 65</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>R. Darryl Fisher, MD</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-24-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>R. DARRYL FISHER</b>						23D. ADDRESS <b>Johns Hopkins Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>				24B. DATE <b>4-27-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Anatomy Board</b>				24D. LOCATION (City, town, or county) (State) <b>University Hospital Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>				ADDRESS	



39-51-53 AM

BALTIMORE CITY HEALTH DEPARTMENT

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 4664

65 4664

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Alphonso Bettis

2. DATE AND HOUR OF DEATH

4-22-65

5:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland, Carroll

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Sykesville

D. STREET ADDRESS (If rural, give location)

Route 1, Box 33

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-14-87

9. AGE (In years  
last birthday)

77

If Under 1 Yr.  
Months: DaysIf Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

418 1828 74

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 3 01X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia  
DUE TO

1 Week

ANTECEDENT CAUSES

(B) Chronic Laryngobronchitis  
DUE TO

1 Year

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

(R) Hydronephrosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-23- 19 65 to 4-22- 19 65,  
that (I) (we) last saw the deceased alive on 4-22- 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Kenneth N. Walton

M.D. Attending  
Phys. ☐Med.  
Director ☐Stoff  
Phys. ☒

23B. DATE SIGNED

4-22-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Kenneth N. Walton

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION, etc. DATE  
REMOVAL (Specify)

MAY 3 1965

24C. NAME OF CEMETERY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

25B. NAME OF REGISTRAR

Robert E. Fink

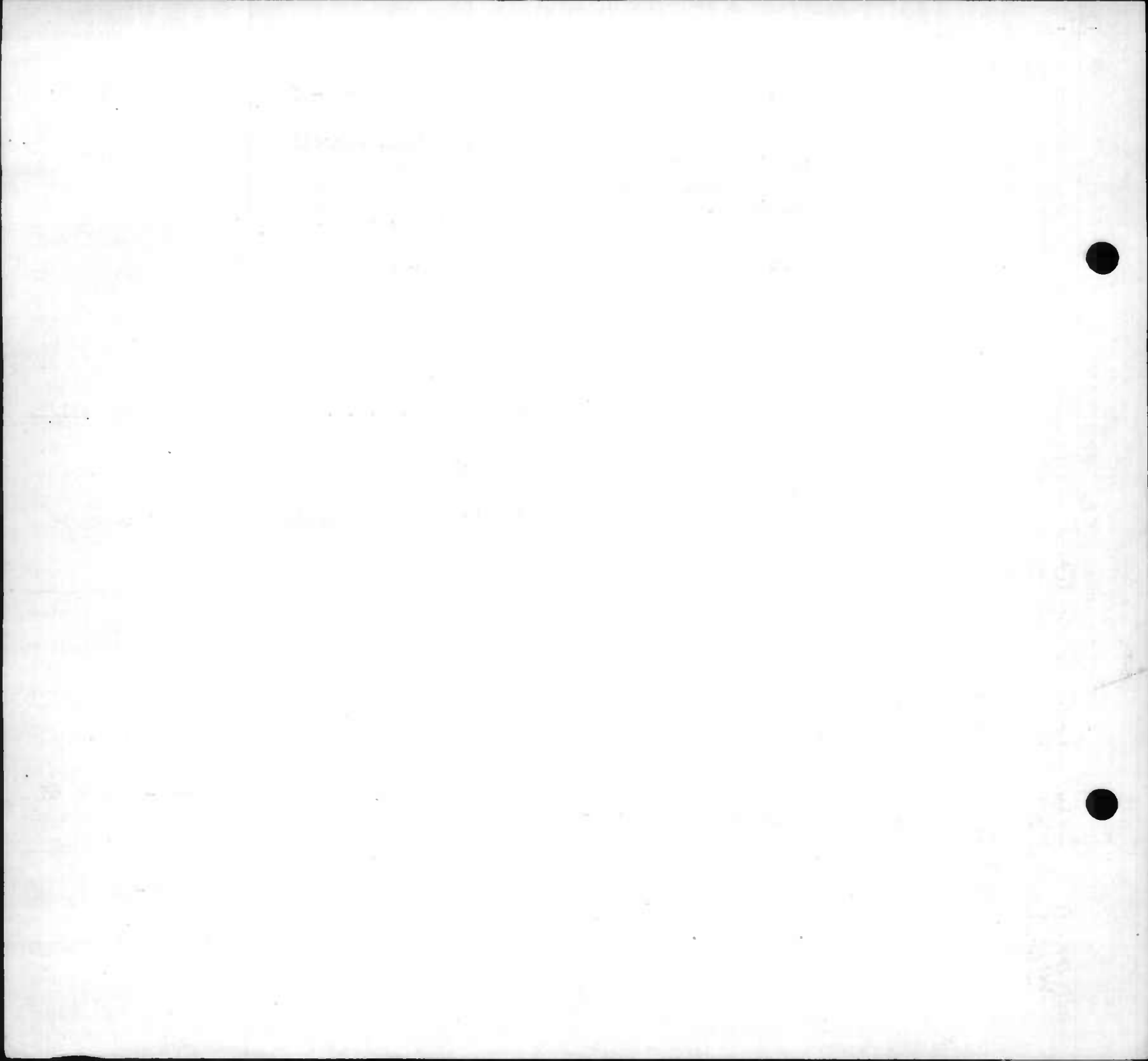
25C. FUNERAL DIRECTOR

MORTUARY SERVICE - BCHD

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

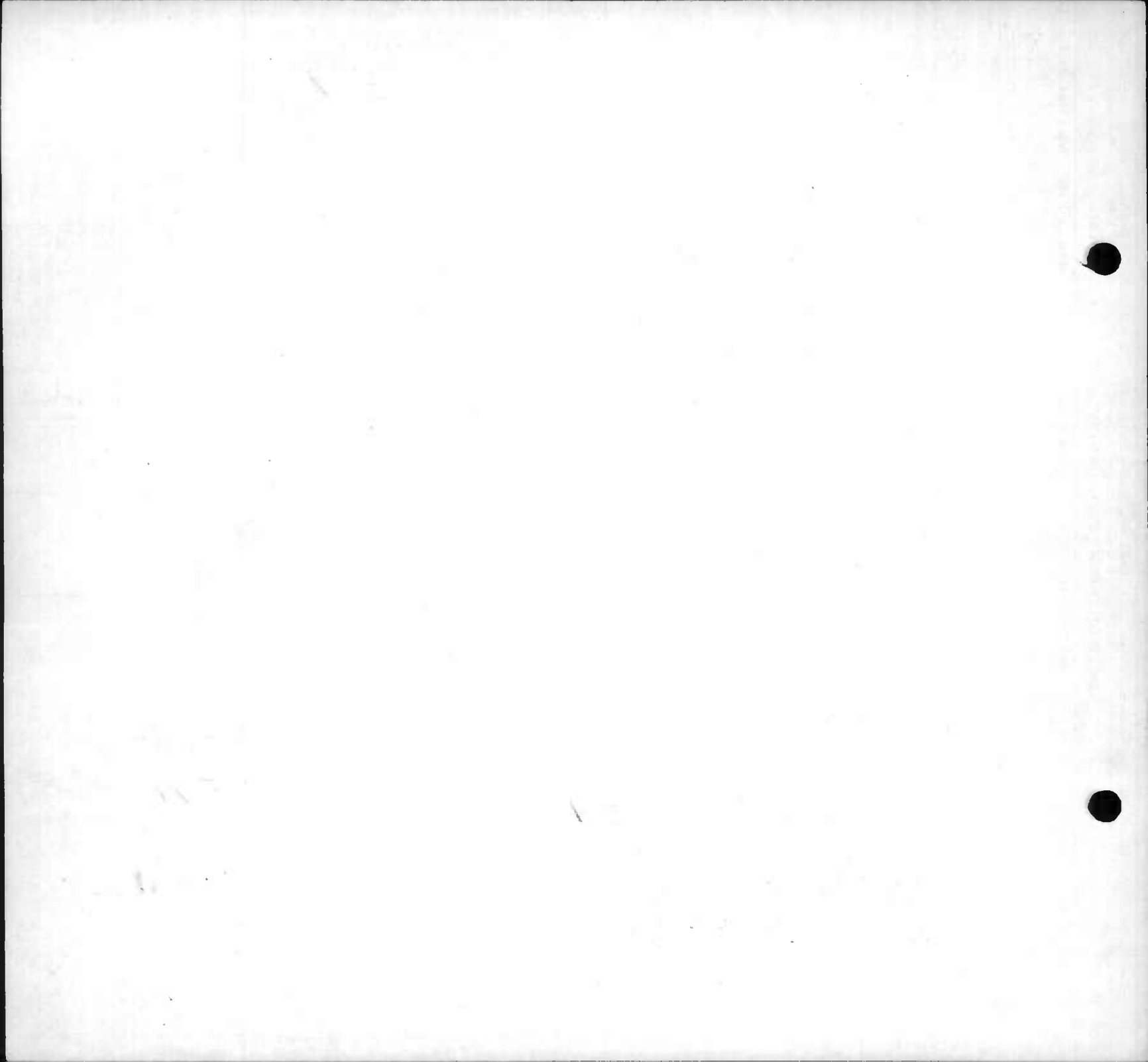




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

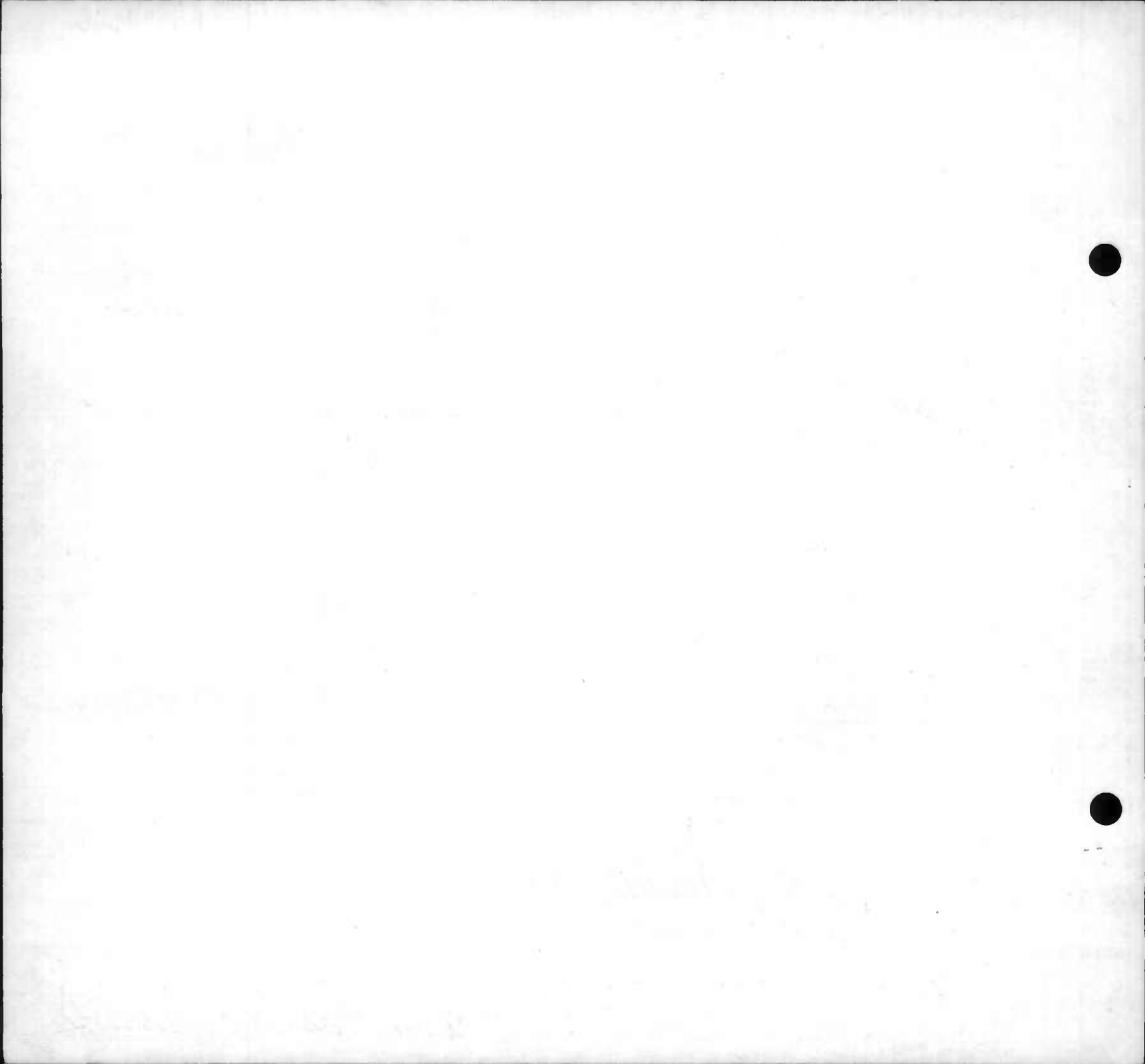
BALTIMORE CITY HEALTH DEPARTMENT									
65 4665 CERTIFICATE OF DEATH					Registered No. 65 4665				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Earl Lorraine Souder</b>					2. DATE AND HOUR OF DEATH <b>5/11/65 1:50 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>					A. STATE <b>Md.</b>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 21213</b>				
					D. STREET ADDRESS (If rural, give location) <b>1646 Darley Avenue</b>				
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/25/00</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dispatcher Transportation Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Md. Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Souder</b>					14. MOTHER'S MAIDEN NAME <b>Emma Gross</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>215 03 2700</b>		17. INFORMANT <b>Robert E. Stoner</b>				ADDRESS <b>University Hospital</b>
18. <b>433.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH
					(A) <b>Arteriosclerotic Cardiovascular Disease</b>				<b>Years</b>
					(B) <b>Stokes Adams Syndrome</b>				<b>1 Year</b>
					(C) <b>Controlled &amp; Artificial Pacemaker</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					20A. AUTOPSY? (Yes or No) <b>NO</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from <b>4/1</b> 19 <b>65</b> to <b>5/11</b> 19 <b>65</b> , that (2) (we) last saw the deceased alive on <b>5/11</b> 19 <b>65</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Robert E. Stoner, MD</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/11/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Stoner</b>					23D. ADDRESS <b>University Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Louder Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Stoner</b>		25C. FUNERAL DIRECTOR <b>Henry Sander &amp; Sons Inc.</b>		ADDRESS <b>Baltimore Maryland</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4666	
BIRTH NO. 65 4666		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>GARRETT HARDING</i>						2. DATE AND HOUR OF DEATH <i>4-30-65</i> <i>1:40 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>15-02</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 17</i>					
						D. STREET ADDRESS (If rural, give location) <i>1805 BAKER STREET</i>					
5. SEX <i>MALE</i>		6. RACE <i>NEGRO</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>6-28-99</i>		9. AGE (In years last birthday) <i>65</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>N.J.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>THOMAS HARDING</i>						14. MOTHER'S MAIDEN NAME <i>FLORA</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>218-10-2591</i>		17. INFORMANT <i>Mary Harding</i>				ADDRESS <i>1805 Baker St</i>	
18. <i>581.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hepatic Failure</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cirrhosis</i>						CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i> <i>unknown</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>				20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>-</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>							
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>April 29, 1965</i> to <i>April 30, 1965</i> , that (I) ( <del>was</del> ) last saw the deceased alive on <i>April 30, 1965</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <i>Kenneth E. Quickel Jr.</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <i>4-30-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kenneth E. Quickel Jr.</i>						23D. ADDRESS M.D. <i>Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-5-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>George H. Viker</i>		ADDRESS <i>1348 N. Calhoun St</i>					



BIRTH NO. 65 4667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4667

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPH MOORING</b>			2. DATE AND HOUR PRONOUNCED DEAD <b>4/30/65 7:25 a.</b>		
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>823 Appleton St.</b>		
5. SEX <b>male</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3-6-16</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
13. FATHER'S NAME <b>Rouse Mooring</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Staton</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>142-18-8311</b>		17. INFORMANT ADDRESS <b>Evie D. Mooring 823 Appleton St.</b>	
18. I <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty alteration of the liver</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>W.U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/30/65</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5-5-65</b>		23C. NAME of CEMETERY or CREMATORY <b>Church Pers.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Salvatore A. Keker 1348 N. Calhoun St</b>	

# VALLEY FORGE

VALLEY FORGE

VALLEY FORGE

VALLEY FORGE

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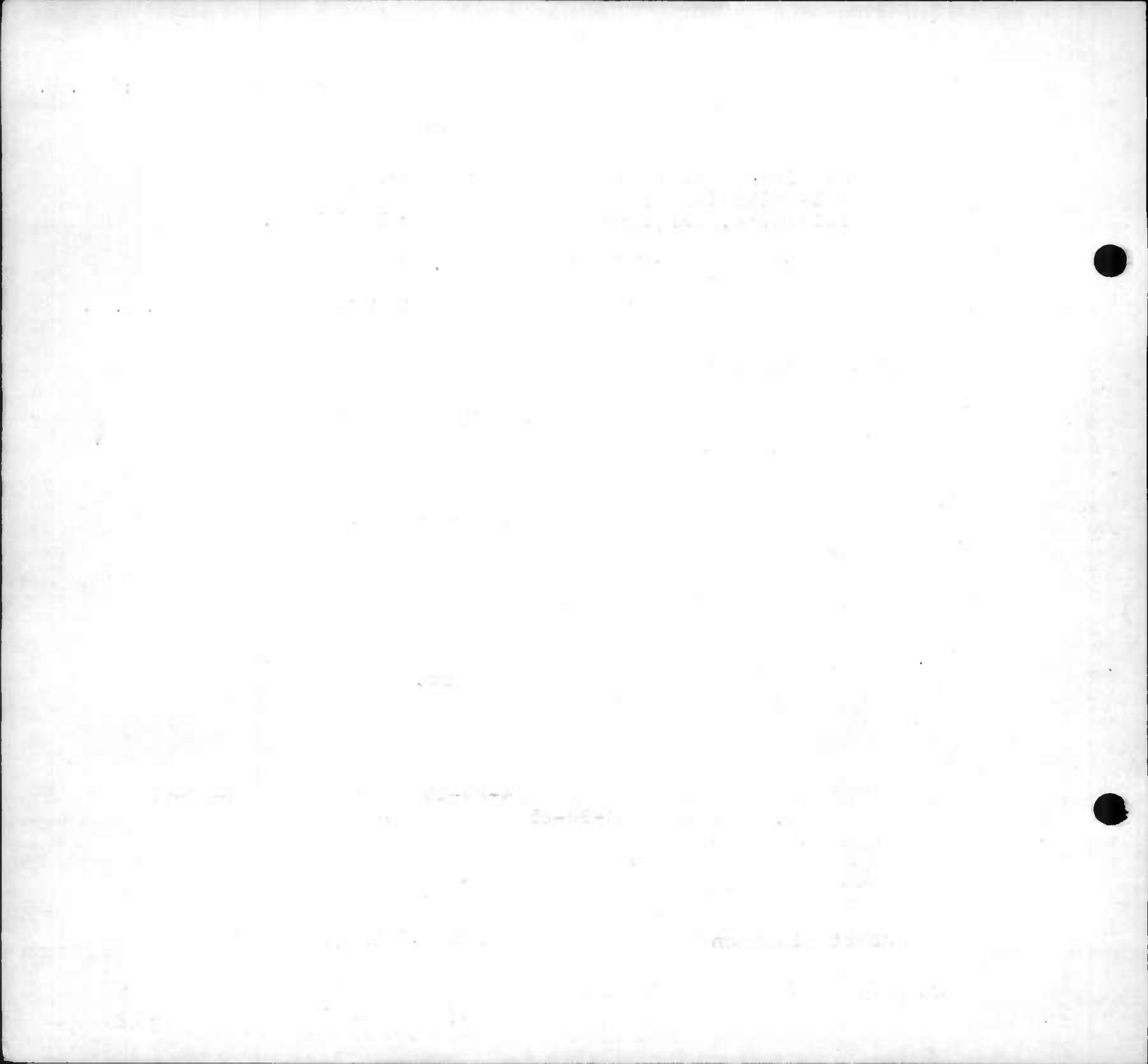
VALLEY FORGE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4668</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4668</span>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">LEON PALMER</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 30 1965</span>   <span style="font-size: 1.2em;">6:50 P. M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Provident Hospital 1514 Division Street Baltimore, Maryland</span>				A. STATE <span style="font-size: 1.2em;">Maryland</span>			
				B. COUNTY <span style="font-size: 1.2em;">13-03</span>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2428 Druid Hill Ave.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Aug. 25 1894</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Retired</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Mend Palmer</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Julia</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">315-10-0529</span>		17. INFORMANT <span style="font-size: 1.2em;">Lucy Palmer</span>		ADDRESS <span style="font-size: 1.2em;">VA.</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Uremia</span>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">Nephrosclerosis</span>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Arteriosclerosis</span>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No.</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4-29-65</span> 19 to <span style="font-size: 1.2em;">4-30-65</span> 19, that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">4-30-65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">K. Blackmon</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/1/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert Blackmon</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">1514 Division Street</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">F-5-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Church Cem.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Richmond Co. VA.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 3 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farkner</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Joseph L. Kline</span>		ADDRESS <span style="font-size: 1.2em;">1348 N. Calhoun St</span>	

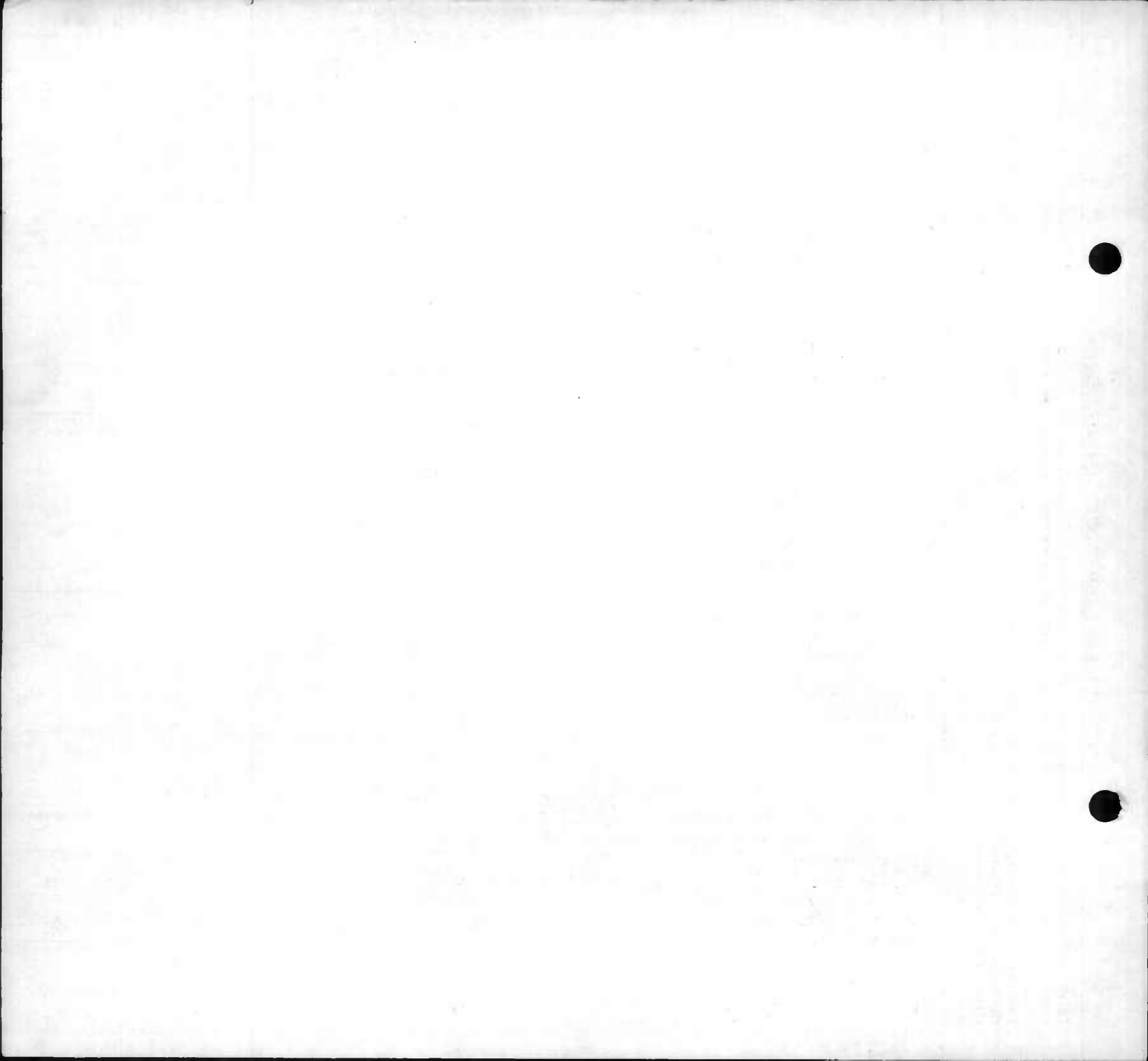




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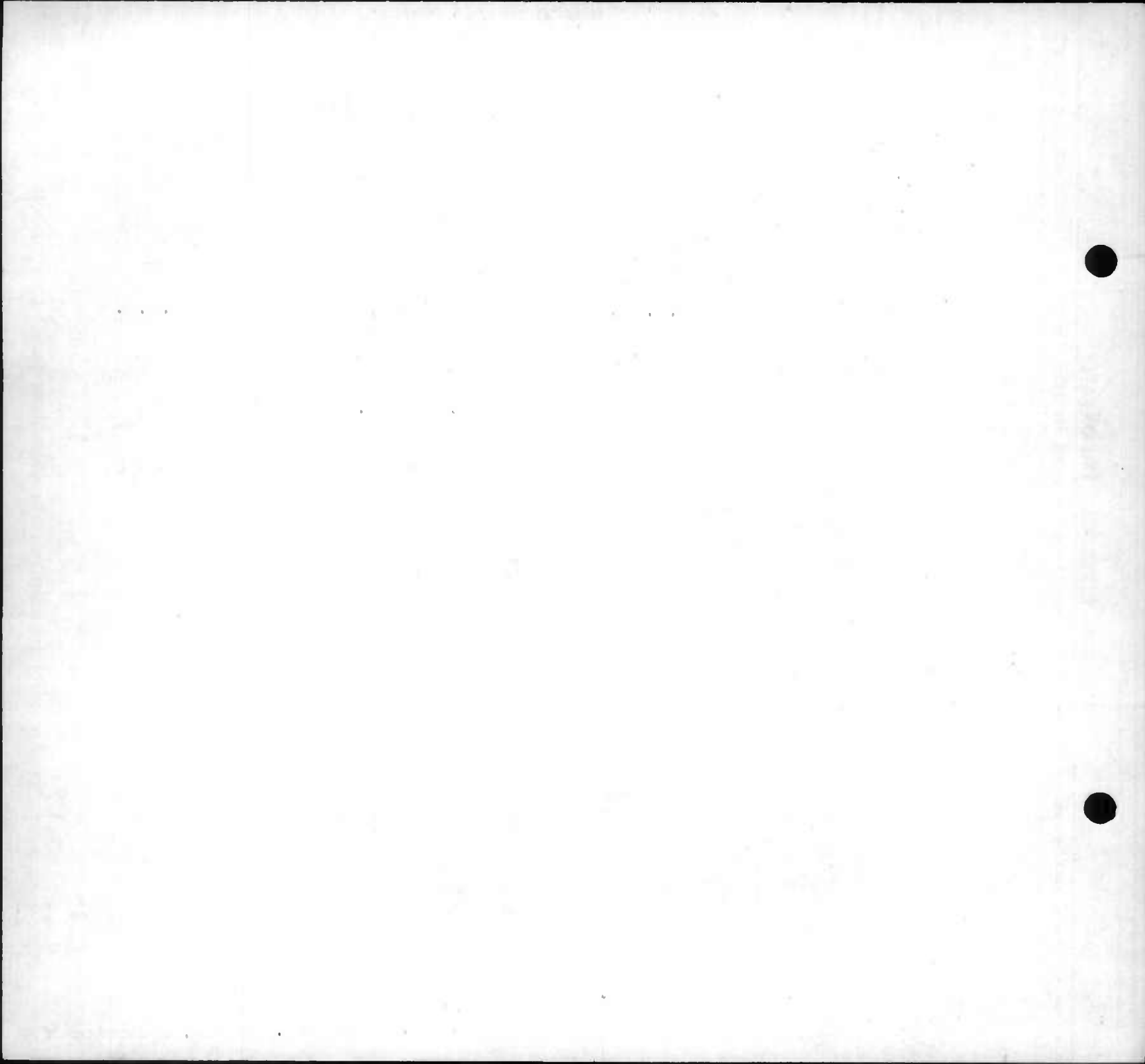
BIRTH NO. 65 4669		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4669	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>AUGUST L. KRUEGER</b>		2. DATE AND HOUR OF DEATH <b>April 29, 1965 10:40 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>6-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>214 N. GLOVER ST.</b>		(If not in hospital) or institution, give street address or location		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>214 N. GLOVER ST.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>SEPT. 9, 1905</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MEAT PACKING.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b>	
13. FATHER'S NAME <b>FRANK KRUEGER</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE Deuling.</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-03-9392</b>		17. INFORMANT ADDRESS <b>MARIE KRUEGER 214 N. GLOVER ST.</b>	
18. <b>199.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMA TOSIS (PRIMARY - UNKNOWN)</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0 MARCH 1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>EXPLORATORY</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/13/64</b> 19 to <b>4/29/65</b> 19, that (I) (we) last saw the deceased alive on <b>4/28/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>BENJ. B. MOSES, MD</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/30/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>BENJ. B. MOSES</b>		23D. ADDRESS M.D. <b>448 N. LUZERNE AVE. BALTIMORE, MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-3-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH CEM. BALTIMORE MD</b>	
24D. LOCATION (City, town, or county) (State) <b>MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3, 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>B. DABROWSKI 2818 E. BALTIMORE ST.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 4670					CERTIFICATE OF DEATH					Registered No. 65 4670				
1. NAME OF DECEASED (Type or Print) <i>Edward F. Cash</i>										2. DATE AND HOUR OF DEATH <i>April 30, 1965 9<sup>30</sup> P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1310 Northview Road</i>										A. STATE <i>Maryland</i>				
										B. COUNTY <i>27-09</i>				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
										D. STREET ADDRESS (If rural, give location) <i>1310 Northview Road</i>				
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>8/5/1898</i>		9. AGE (In years last birthday) <i>66</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Purchasing agent</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>					11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>Patrick Cash</i>					14. MOTHER'S MAIDEN NAME <i>Delia Callahan</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW I</i>					16. SOCIAL SECURITY NO. <i>----</i>					17. INFORMANT <i>Mrs. Alma L. Cash</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>163X I</i>					CAUSE OF DEATH <i>Carcinoma of lung</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>Oct 1964</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>metastasis to spine</i>					20A. AUTOPSY? (Yes or No) <i>No.</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased on <i>October 1964</i> to <i>April 26 1965</i> and that (I) (we) last saw the deceased alive on <i>April 26 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										23B. DATE SIGNED				
23A. SIGNATURE <i>W.H.M. Finney</i>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>				
23C. PHYSICIAN'S NAME (Type) <i>W.H.M. FINNEY</i>										23D. ADDRESS <i>18 W. Franklin St. Balt Md</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>5/3/1965</i>					24C. NAME of CEMETERY or CREMATORY <i>New Cathedral Cemetery</i>				
										24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR <i>John A. Moran Inc.</i>				
										ADDRESS <i>3000 E. Baltimore St.</i>				



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4671		CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4671	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) EDITH RICHARDSON		2. DATE AND HOUR OF DEATH April 29, 1965 M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 702 HOMESTEAD ST		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 702 HOMESTEAD ST			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED <del>WIDOWED</del> DIVORCED (specify)	8. DATE OF BIRTH Aug 19, 1892	9. AGE (In years last birthday) 73	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTY OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY HAIR DRESSING		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James William Dunn		14. MOTHER'S MAIDEN NAME Mary Harris	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Meeseke 14 BRAMBLEIGH RD LUTHERVILLE 21093	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 420.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Coronary Sclerosis (C) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (We) attended the deceased from Nov 19 63 to Apr 29 19 65, that (I) (We) last saw the deceased alive on Apr 23 19 65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William F Pearce		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Apr 29, 1965	
23C. PHYSICIAN'S NAME (Type) Wm F Pearce		23D. ADDRESS 2105 N. Charles St			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-1-65		24C. NAME OF CEMETERY or CREMATORY Mt Olivet Cemetery	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. 1050 York Rd			

Maxwell  
Miss  
A. J. J.

James  
James  
James

James

# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>S-162</span> <span>1</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Frederick Mem. Hosp. Md.</span> <span>Baltimore City Health Department</span> </div>		<b>CERTIFICATE OF DEATH</b>		Registered No. <u>65 4672</u>	
BIRTH NO. <u>65 4672</u> M.E. CASE NO. <u>65 4672</u>		1. NAME OF DECEASED (Type or Print) <u>Brian Lee Sparkman</u>			
2. DATE AND HOUR OF DEATH <u>4/28/65 10:45 a.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MIDDLE TOWN</u> B. COUNTY <u>MARYLAND</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Frederick</u>			
D. STREET ADDRESS (If rural, give location) <u>RT-2 # 60-00</u>					
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, <del>DIVORCED</del> (specify)	8. DATE OF BIRTH <u>11.19.64</u>	9. AGE (In years last birthday) <u>5 mo</u>	If Under 1 Yr. Months: <u>5</u> Days: <u>9</u> Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>*</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>*</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. Sparkman</u>			
14. MOTHER'S MAIDEN NAME <u>Barbara Ann Repp</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT <u>Chart</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>754.21</u>		CAUSE OF DEATH (A) DUE TO <u>Congenital heart disease - U.S.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		(B) DUE TO <u>Pulmonary banding</u>			
(C) <u>Congenital</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>X</u>					
19A. DATE OF OPERATION <u>4-27-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>U.S.D. pulmonary hypertension</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4. 6</u> 19 <u>65</u> to <u>4-28</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>10:45am 4-28</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Chetan Dev. M.D.</u> M.D.				23B. DATE SIGNED <u>4.28.65</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHETAN DEV.</u>		23D. ADDRESS <u>University Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-1-65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Grady H. B. Middletown, Md.</u>	

Thursday, 11/14/64

11/14/64

Game 11  
Clare

Game 12  
Clare

11/15/64

11/15/64

Game 13  
Clare

Game 14  
Clare



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

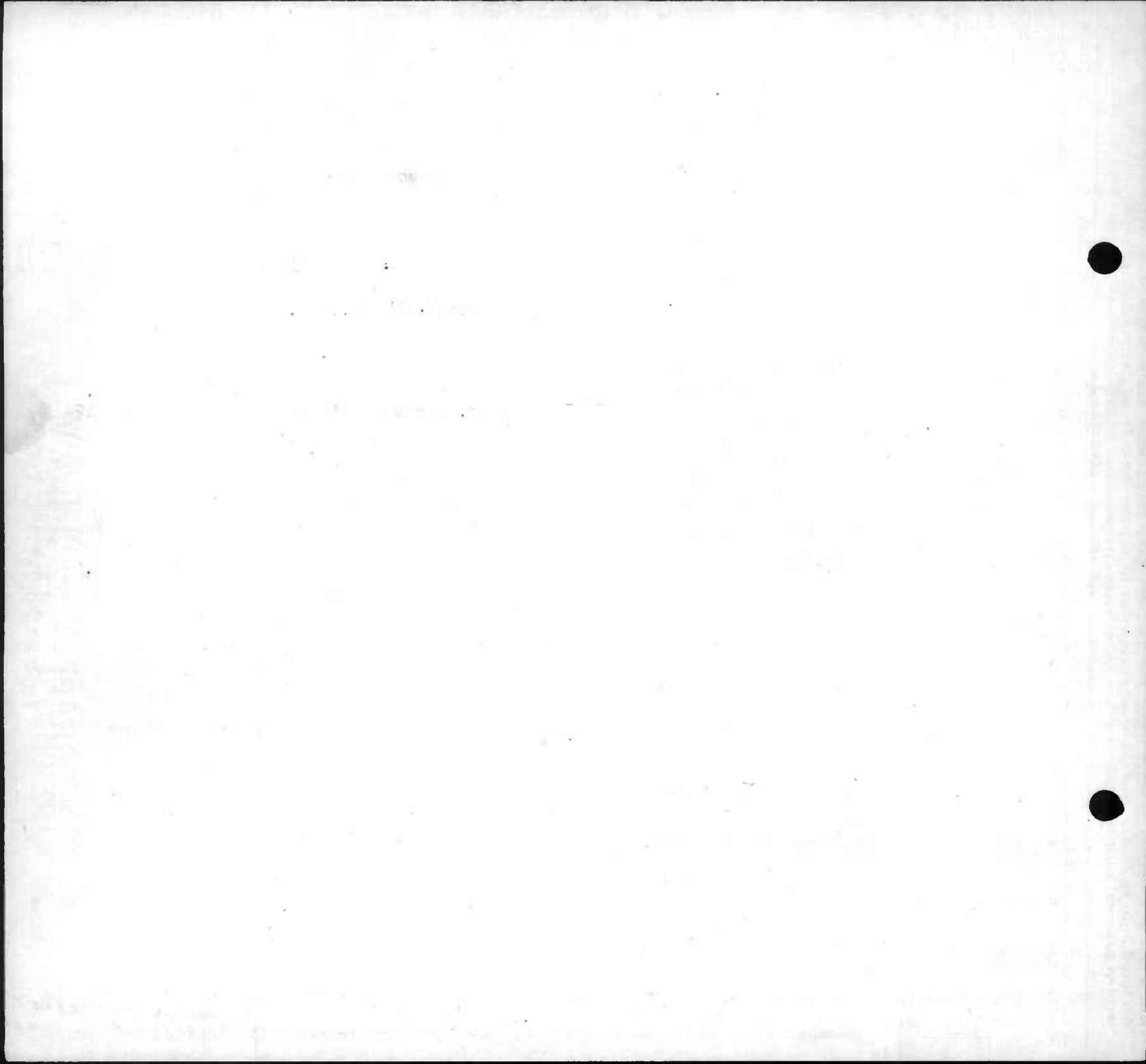
BIRTH NO. 65 4673		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4673	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Jeanette Belle Jones		2. DATE AND HOUR OF DEATH May 2, 1965 1:45 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 12-03			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 328 Ilchester Ave			
5. SEX Female	6. RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1-21-11	9. AGE (In years last birthday) 54	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME E.C. Jones		14. MOTHER'S MAIDEN NAME LILUF B. Jones	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 218-32-0563		17. INFORMANT Albert A. Jones	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 430.01		CAUSE OF DEATH (A) Acute Myocardial Infarct, Massive DUE TO Acute Bacterial aortic and (B) Mitral Valvular Disease Valvulitis (C) Broncho pneumonia, confluent.		ADDRESS Same	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-1-65 19 to 5-2-65, that (I) (we) last saw the deceased alive on May 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Charles T. Fletcher		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 2, 1965	
23C. PHYSICIAN'S NAME (Type) CHARLES T. FLETCHER		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/1965		24C. NAME OF CEMETERY OR CREMATORY Parkwood	
24D. LOCATION Parkville, Balto. Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR R. E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.	
				ADDRESS 4905 York Road Baltimore 12, Md.	

100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

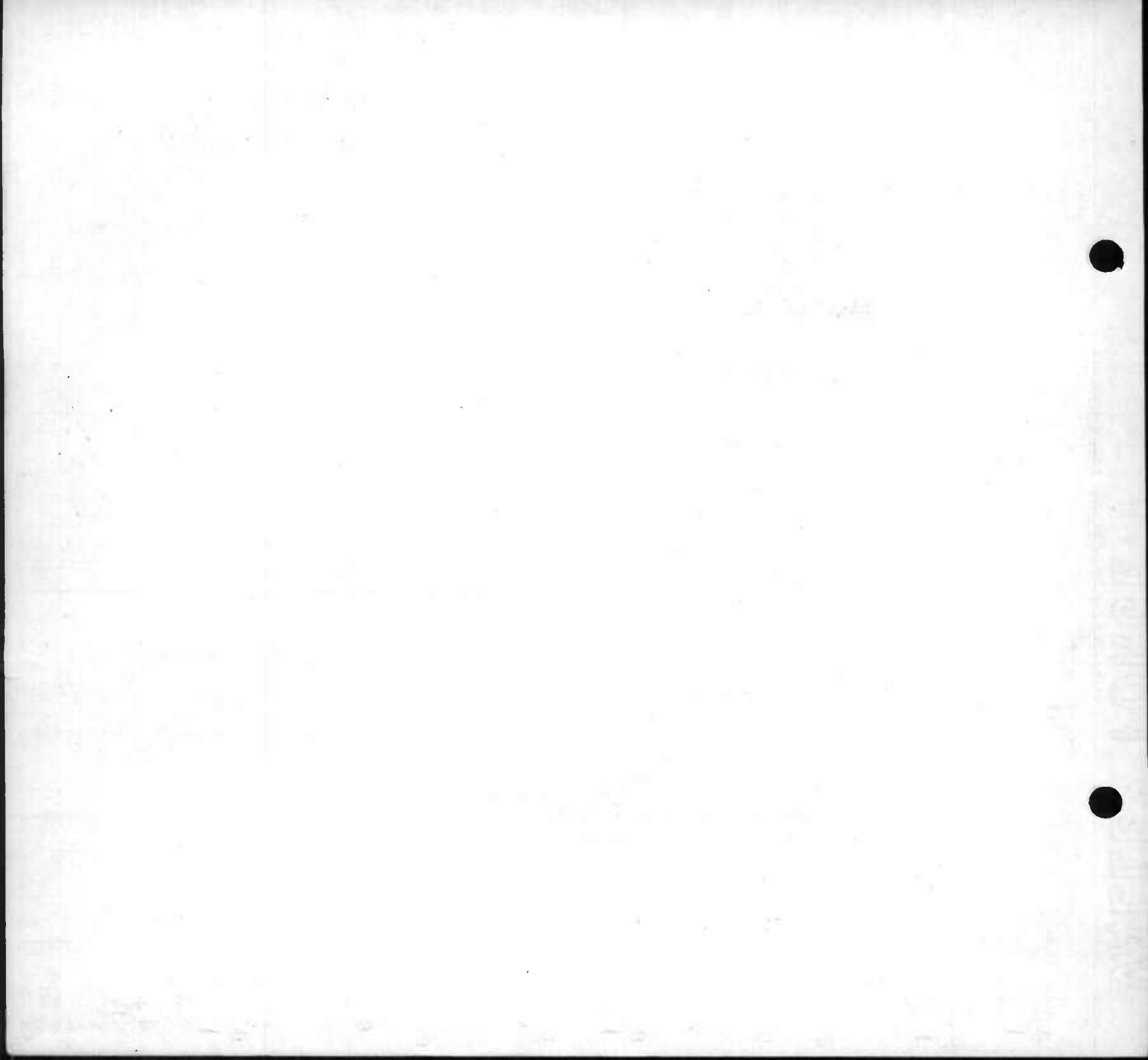
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 4674</span>	
BIRTH NO. <span style="float: right;">65 4674</span>				CERTIFICATE OF DEATH	
M.E. CASE NO. <span style="float: right;">65 4674</span>				1. NAME OF DECEASED (Type or Print) <span style="float: right;">O'HARA Dr. JOHN J.</span>	
2. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH <span style="float: right;">4/30/65 15.05 P. M.</span>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="float: right;">MARYLAND GENERAL HOSPITAL 827 LINCOLN AVE BALTO 1, MD</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="float: right;">MARYLAND</span> B. COUNTY <span style="float: right;">Balto</span>	
5. SEX <span style="float: right;">M</span> 6. RACE <span style="float: right;">W</span> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="float: right;">MARRIED</span>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="float: right;">Rogers Forge</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="float: right;">RETIRED</span>				D. STREET ADDRESS (If rural, give location) <span style="float: right;">6815 BLENHEIM RD. 12</span>	
10B. KIND OF BUSINESS OR INDUSTRY <span style="float: right;">PHARMACIST</span>				8. DATE OF BIRTH <span style="float: right;">8/30/91</span> 9. AGE (In years last birthday) <span style="float: right;">73</span>	
13. FATHER'S NAME <span style="float: right;">WOODWARD A. O'HARA</span>				11. BIRTHPLACE (State or foreign country) <span style="float: right;">Frederick Co., Md.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				12. CITIZEN OF WHAT COUNTRY? <span style="float: right;">U.S.A</span>	
16. SOCIAL SECURITY NO. <span style="float: right;">216-32-5680</span>				14. MOTHER'S MAIDEN NAME <span style="float: right;">HATTIE F. SCARF</span>	
17. INFORMANT <span style="float: right;">Mrs. Irene V. O'Hara</span>				ADDRESS <span style="float: right;">6815 Blenheim Rd. Zone 12</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <span style="float: right;">443X1</span>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) <span style="float: right;">HYPERTENSIVE CARDIO-VASCULAR DISEASE</span> (B) <span style="float: right;">ANEURYSM OF ABD. AORTA</span> (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="float: right;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="float: right;">Yes</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">3/26</span> 19 <span style="float: right;">65</span> to <span style="float: right;">4/30</span> 19 <span style="float: right;">65</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">4/30</span> 19 <span style="float: right;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="float: right;">Pietro Lastrucci</span>				23B. DATE SIGNED <span style="float: right;">4/30/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">LASTRUCCI PIETRO</span>				23D. ADDRESS <span style="float: right;">MARYLAND GEN. HOSP.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="float: right;">Burial</span>		24B. DATE <span style="float: right;">5/4/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="float: right;">Woodlawn Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="float: right;">Woodlawn, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">MAY 3 1965</span>		25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Schaefer</span>	
25C. FUNERAL DIRECTOR <span style="float: right;">Wm. J. Fisher &amp; Sons</span>		25D. ADDRESS <span style="float: right;">Baltimore, Md. 21217</span>		25E. ADDRESS <span style="float: right;">North Pa. Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

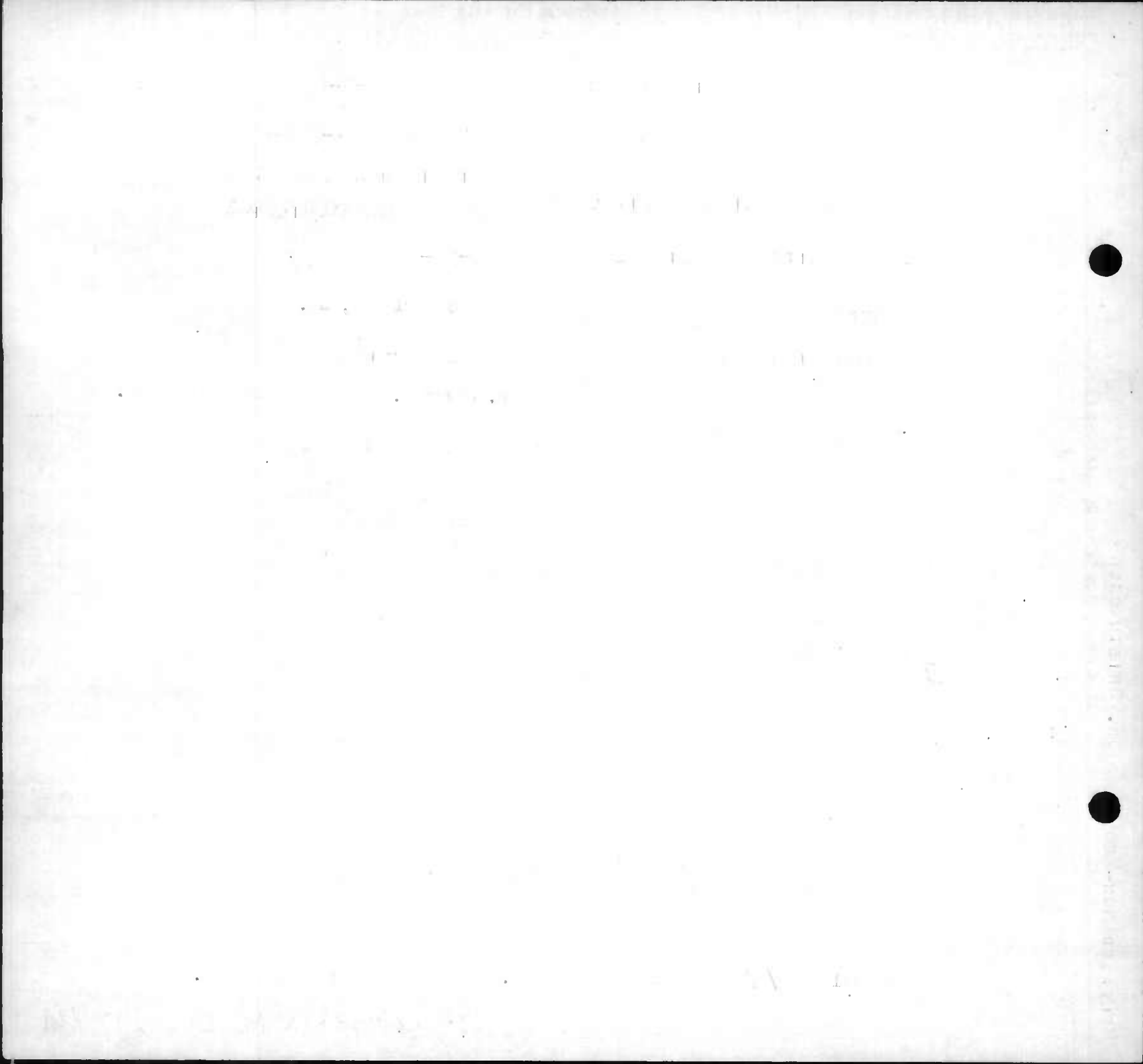
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH									
BIRTH NO. 65 4675		Registered No. 65 4675							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>William Edgar Ross</u>				2. DATE AND HOUR OF DEATH <u>5-1-65</u> <u>10</u> <u>30</u> <u>PM</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Towson</u> <u>53-00</u>		D. STREET ADDRESS (If rural, give location) <u>510 Club Lane</u> <u>4</u>	
5. SEX <u>M</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>2-2-77</u>	9. AGE (In years last birthday) <u>88</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Commercial Credit</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alonzo Ross</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Catherine Bond Ross</u> ADDRESS <u>510 Club Lane Towson, Md.</u>			
18. CAUSE OF DEATH									
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>422.1</u>				(A) DUE TO <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9-10 days</u>	
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <u>Arterio Sclerotic Cardio-Vascular disease</u>					
				(C) <u>disease</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (if) (this hospital) attended the deceased from <u>4-22-65</u> to <u>5-1-65</u> , that (if) (we) last saw the deceased alive on <u>5-1-65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Rodney L. Brimhall</u> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-1-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>RODNEY L. BRIMHALL</u>				23D. ADDRESS <u>Union Memorial Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/5/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Floydsburg Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Crest Wood, Kentucky</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Wm. F. Fisher &amp; Sons North - Pa. Ave.</u>		ADDRESS <u>Balto., Md. 21217</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4676				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4676	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				EDMUND RICHARDSON		5-1-65 8:05 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE FLORIDA		B. COUNTY			
THE JOHNS HOKINS HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		PALM BEACH			
				D. STREET ADDRESS (If rural, give location)		XXXXXXXXXXXXXXXXXXXX			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-18-86	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) New Orleans, La.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN RICHARDSON				14. MOTHER'S MAIDEN NAME ELLA OLIVER					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. James K. Jackson			ADDRESS New Orleans La.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute and Chronic Pulmonary Insufficiency and Coronary Artery Disease</i> (B) <i>Pulmonary Emphysema + Coronary Arteriosclerosis</i> (C) <i>Complicated by Surgery</i>				INTERVAL BETWEEN ONSET AND DEATH 30 min 15 years 4 hrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION May 1, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal Aortic Aneurysm		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4/24 1965 to May 1 1965, that (I) (we) last saw the deceased alive on May 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Howard C. Richter				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/1/65			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 5/5/65		24C. NAME OF CEMETERY or CREMATORY Lafayette Cent.		24D. LOCATION (City, town, or county) (State) New Orleans La.			
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR Robert E. Folsom		25C. FUNERAL DIRECTOR Wm. J. Dickson		ADDRESS Louis Ma. Belto 17. Ind.			

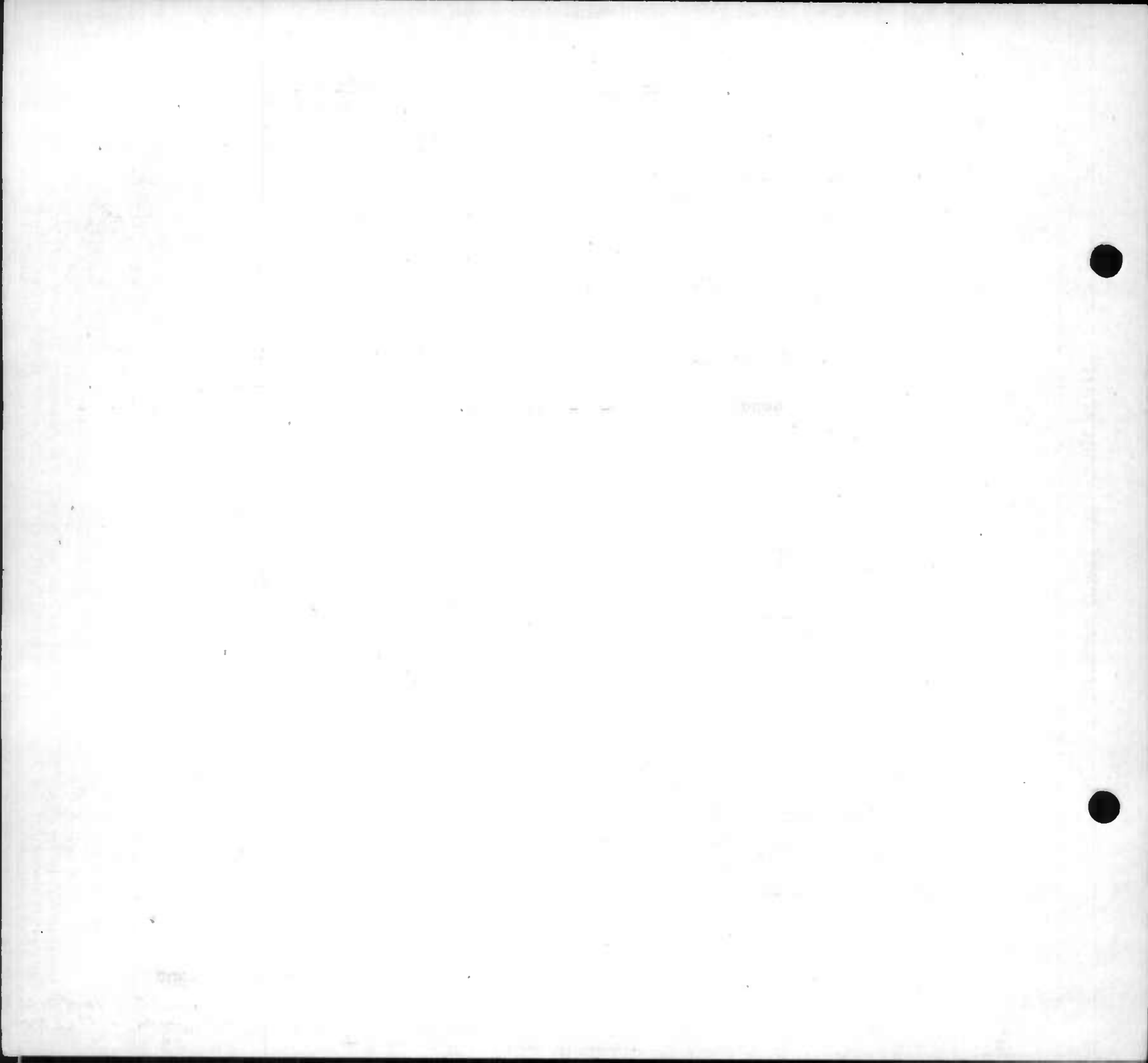




# FUNERAL DIRECTOR: IMPORTANT

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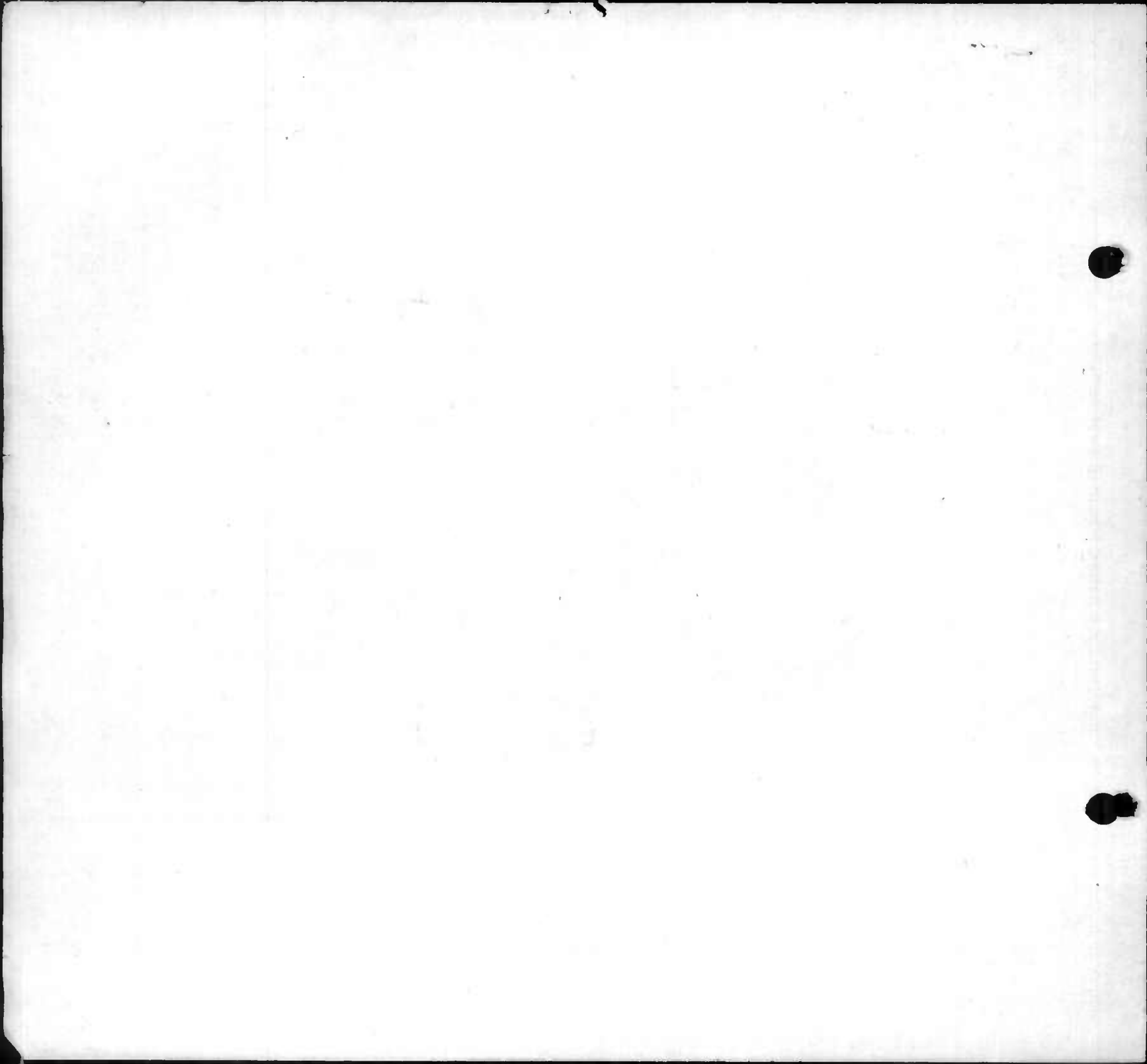
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 4677					CERTIFICATE OF DEATH					Registered No. 65 4677				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH									
1. NAME OF DECEASED (Type or Print) Charles S. Ohrenschall					April 30, 1965					9 35 AM				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Garrison Nursing Home					A. STATE Maryland					B. COUNTY 12-02				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore									
					D. STREET ADDRESS (If rural, give location) 4 East 32nd Street					21218				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single		8. DATE OF BIRTH		9. AGE (In years last birthday) About 76		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant				10B. KIND OF BUSINESS OR INDUSTRY Engineering				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles A. Ohrenschall					14. MOTHER'S MAIDEN NAME Minnie ?									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None					16. SOCIAL SECURITY NO. 218-07-3034		17. INFORMANT Mr. William Haesloop					ADDRESS 121 Regester Ave. Baltimore, Md. 12		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.11 Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH 1 wk.				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HASCVD, severe										years.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial infarction, old										1 yr.				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
0				no										
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 7/2/59 to 4/30/65, that (I) (we) last saw the deceased alive on 4/28/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Philip Whittlesy					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 4/30/65				
23C. PHYSICIAN'S NAME (Type) Philip Whittlesy					23D. ADDRESS M.D. 600 W. Belvedere Ave, Baltimore									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/1965		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland								
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Wm. F. Dickman & Son		ADDRESS Baltimore, Md. 21217								



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4678		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4678	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) LEVY SARA		2. DATE AND HOUR OF DEATH 4-30-65 5:40 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE CO. MD. Balto B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTO. INC. BEWEDE AVE AT GREENSPRING BALTIMORE 15, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 5300			
D. STREET ADDRESS (If rural, give location) 133 SLATE AVE 20158					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10-1-74	9. AGE (In years, last birthday) 90	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) District of Columbia, U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nathan Blum		14. MOTHER'S MAIDEN NAME Jeanette Levy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. John Stemmler Broadview Apts. Balto. Md	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the injury or complication which caused death.) ACUTE PULMONARY EDEMA POSTERIOR MYOCARDIAL INFARCTION CORONARY INSUFFICIENCY ARTERIO-SCLEROTIC HEART DIS.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERTROCHANTERIC FX, LEFT HIP FX, SURGICAL NECK RT. HUMERUS			
19A. DATE OF OPERATION 4-27-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FX, LEFT HIP		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from 4-26-65 19 to 4-30-65 19, that (I) (we) last saw the deceased alive on 4-30-65 5:40 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas J. Conception Jr. M.D.				23B. DATE SIGNED 4-30-65	
23C. PHYSICIAN'S NAME (Type) THOMAS J. CONCEPTION JR. M.D.				23D. ADDRESS 90 SINAI HOSP. OF BALTIMORE, INC.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24B. DATE 5/3/65		24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William J. Ticken & Son Inc. N. Calver	



65 4679

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4679

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

KLAUS K. RESZIES

2. DATE AND HOUR PRONOUNCED DEAD

4/29/65 9:07 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Dundalk

D. STREET ADDRESS (If rural, give location)

1804 Maxwell Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 1- 1935

9. AGE (in years  
last birthday)

30

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Sheet metal worker

10B. KIND OF BUSINESS OR INDUSTRY

Owens Yacht Co.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Kurt Reszies

14. MOTHER'S MAIDEN NAME

Eva Reszies

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

231-50-7002

17. INFORMANT

ADDRESS

Wife, Mrs. Ottilie Reszies, # 4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Extensive cranio-cerebral injury

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Belair Rd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 29 65 8:40p.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May-4-1965

23C. NAME of CEMETERY or CREMATORY

Christ Lutheran Church Cemetery German Hill Rd. Dundalk

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert G. Falko, M.D.

24C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

ADDRESS

Near Mary Ave.

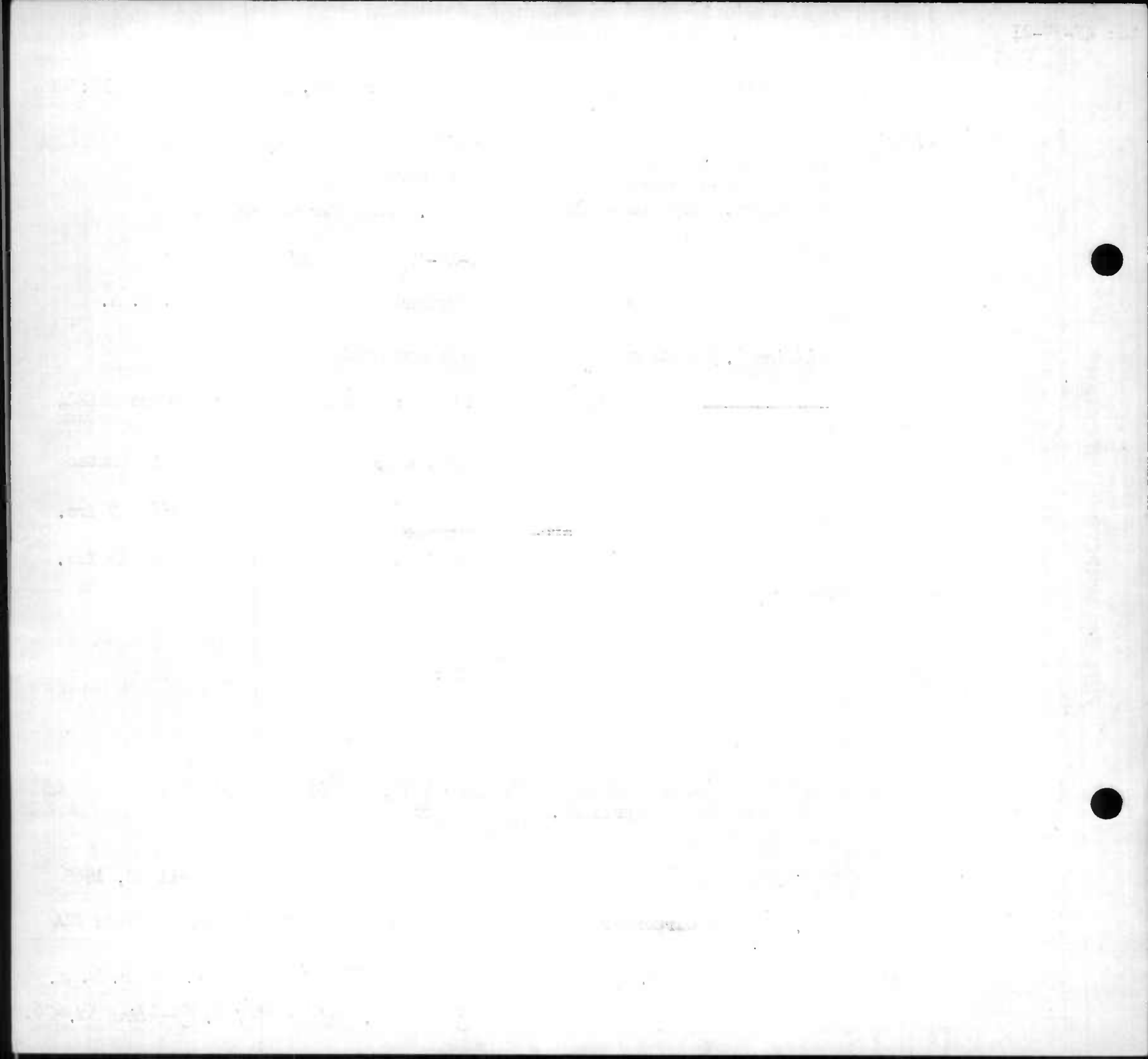
C-516  
LS: 43-39-21

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4680				CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4680			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <u>Edward William Cumberland</u>				2. DATE AND HOUR OF DEATH <u>April 28, 1965</u> <u>12:30A</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-07</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				D. STREET ADDRESS (If rural, give location) <u>640 S. Ponca Street #21224</u>							
5. SEX <u>Male</u>		6. RACE <u>White</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>2-17-48</u>		9. AGE (In years last birthday) <u>17</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William E. Cumberland</u>				14. MOTHER'S MAIDEN NAME <u>Rose Lee Petty</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>RECORDS: BCH: 4940 Eastern Avenue #21224</u>				ADDRESS			
18. <u>434.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>Cardiac Arrest</u> DUE TO (B) <u>Kyphoscoliotic Cardio Pulmonary Disease</u> (C) <u>Multiple Congenital Deformities</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 Minutes</u> <u>17 Yrs.</u> <u>17 Yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1965</u> to <u>April 28, 1965</u> , that (I) (we) last saw the deceased alive on <u>April 28, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Dr. Charles Carpenter</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>April 28, 1965</u>					
23C. PHYSICIAN'S NAME (Type) <u>Dr. Charles Carpenter</u>				M.D. 23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland #24</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-1-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Carmel Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>5712 O'Donnell St. Balto. 24, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Charles S. Zeiler</u>		ADDRESS <u>901 S. Conkling St. #24</u>					







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4681					CERTIFICATE OF DEATH				
Registered No. 65 4681									
1. NAME OF DECEASED (Type or Print) <i>Anthony C. Thomas</i>					2. DATE AND HOUR OF DEATH <i>April 28, 1965 10:00 P.M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Balto. City Hospitals</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-11</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>3323 Foster Avenue #24</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>1-26-95</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Revere Brass &amp; Copper</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Thomas</i>					14. MOTHER'S MAIDEN NAME <i>Anna Siharek</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Margaret M. Thomas</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO <i>Coronary artery disease</i> (B) DUE TO <i>Myocarditis</i> (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>Same</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>4-20-65</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(the hospital)</del> attended the deceased from <i>3/25/65</i> to <i>4/28/65</i> that (I) <del>(we)</del> <i>lost</i> saw the deceased alive on <i>3/25/65</i> and that in my <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <i>did</i> (did not) view the body after death.									
23A. SIGNATURE <i>E. A. Flanagan Jr.</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/30/65</i>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-1-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart Cemetery</i>			24D. LOCATION (City, town, or county) (State) <i>7401 German Hill Road Balto. 22, Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>			25C. FUNERAL DIRECTOR <i>Charles S. Zeiler</i>			
						ADDRESS <i>901 S. Conkling Street</i>			

1.21.1944  
2.21.1944  
3.21.1944

21.12.1944

21.12.1944

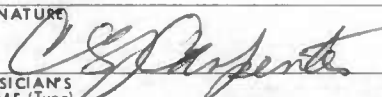
21.12.1944

138-96-12 AM

65 4682

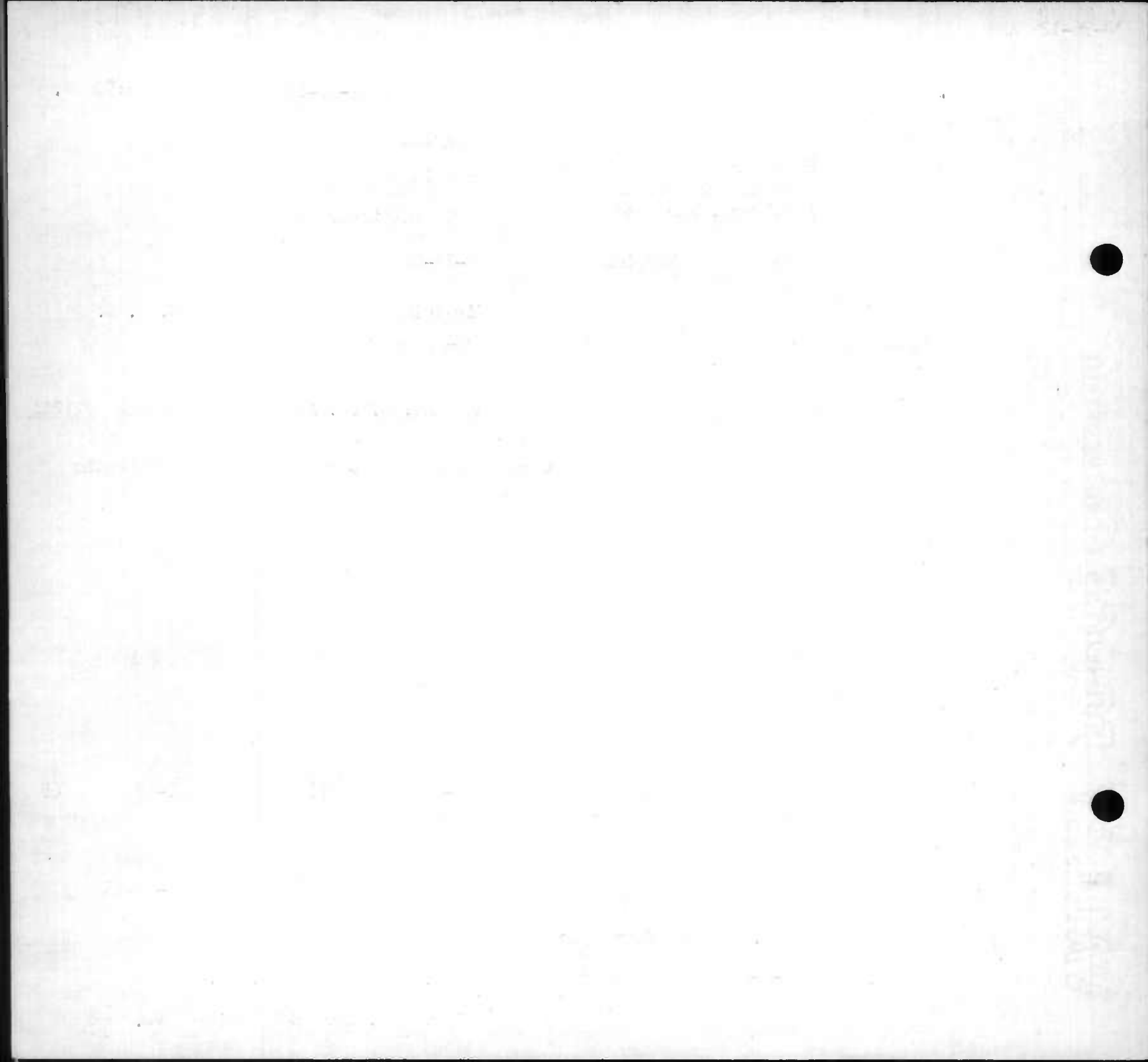
CERTIFICATE OF DEATH

Registered No. 65 4682

BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Conetta Haywood		4-29-65 5:50 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland 12-05			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				Baltimore			
				D. STREET ADDRESS (If rural, give location)			
				409 McAllister Court			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?	
Female	Negro	Married		8-25-04	60	U. S. A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Virginia		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ress Copeland				Dava Ruffins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
				(A) Carcinoma of Breast			
				DUE TO			
				(B) DUE TO			
				(C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
				18 Months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-20 19 65 to 4-29 19 65, that (I) (we) last saw the deceased alive on 4-29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
						4-29-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Charles Carpenter				4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5-3-65		Arbutus Memorial Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 3 1965		Robert E. Fairbank		Charles R. Law		802 Madison Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

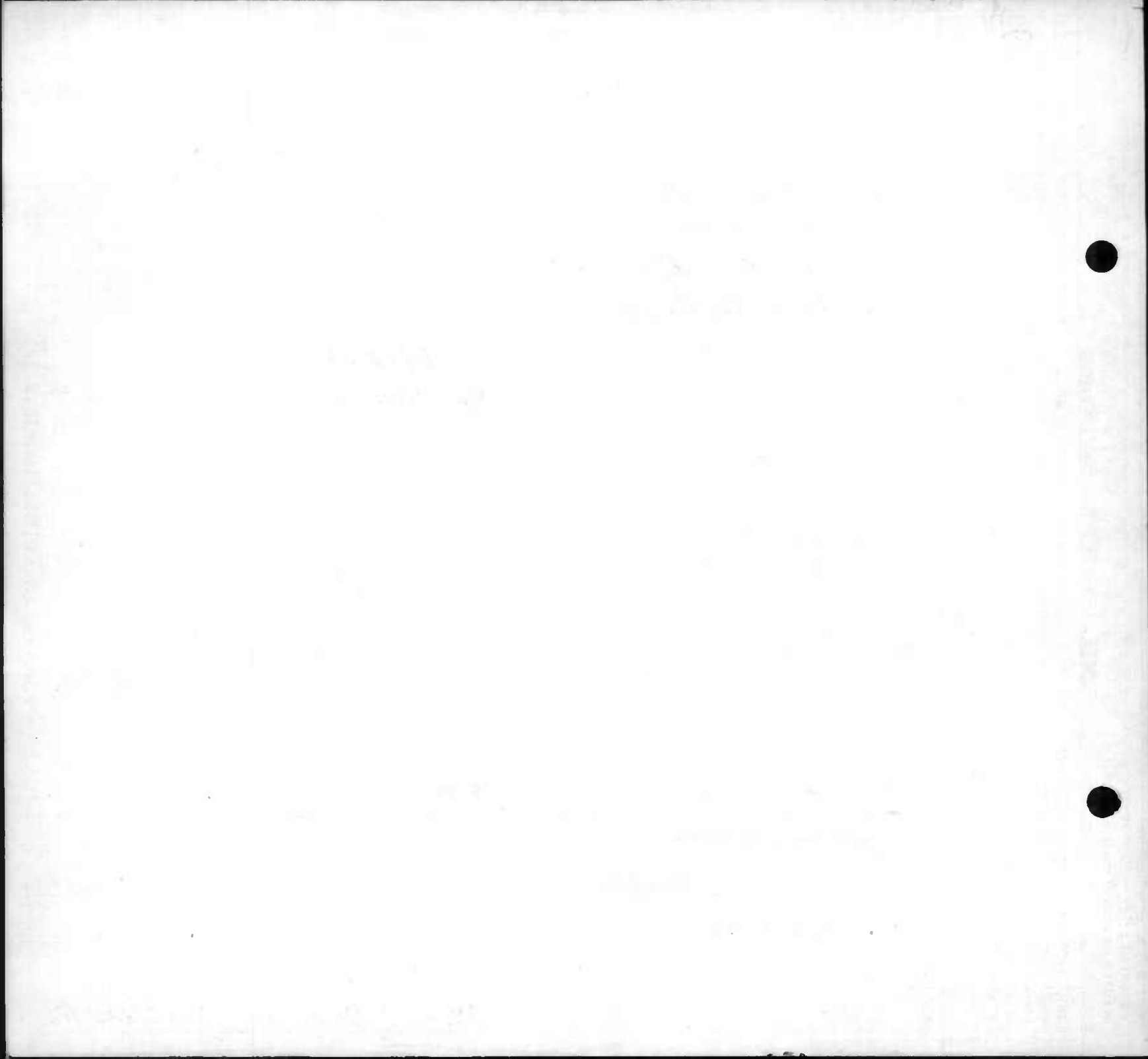
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4683					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4683				
1. NAME OF DECEASED (Type or Print) <b>BLANKNER, FRIEDA E.</b>					2. DATE AND HOUR OF DEATH <b>5-1-65 5:50P M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5202 LEEDS AVE.</b>				
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>	8. DATE OF BIRTH <b>10-1-88</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>CHARLES BEGGEROW</b>			
14. MOTHER'S MAIDEN NAME <b>THERESA LIPPINCOTT</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, No, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>ST AGNES HOSPITAL RECORDS, WILKINS &amp; CATON AVES. 21229</b>			ADDRESS			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Diabetes Mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 15 yrs</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <b>Anteriosclerotic CVD</b> (B) <b>Chronic Cong. Failure</b> (C) <b>CVA → (R) Hemiplegia</b>			20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CVA → (R) Hemiplegia</b>			20A. AUTOPSY? (Yes or No) <b>No</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-7-65</b> to <b>5-1-65</b> , that (I) (we) last saw the deceased alive on <b>5-1-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Frank M. Detorie</b>					23B. DATE SIGNED <b>5/1/65</b>			23C. PHYSICIAN'S NAME (Type) <b>FRANK M. DETORIE</b>	
23D. ADDRESS <b>ST AGNES HOSPITAL, BALTO. 29, MD.</b>					24. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				
24B. DATE <b>5/4/65</b>					24C. NAME OF CEMETERY or CREMATORY <b>Louisa Park Cemetery, Baltimore, Maryland</b>				
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					25. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>				
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>Amber Inc. 1328 Sulphur Sp. Rd.</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 4684		<b>CERTIFICATE OF DEATH</b>		65 4684	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Kriss Blums</b>			2. DATE AND HOUR OF DEATH <b>4-30-65</b> 7 <sup>15</sup> 4 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>13 South Baltimore Gen.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>22-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> # <b>212.30.</b> D. STREET ADDRESS (If rural, give location) <b>814 William St.</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>7-17-1898</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER - LUMBER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired.</b>		11. BIRTHPLACE (State or foreign country) <b>Latvia</b>	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs MARIANA Blums</b> ADDRESS <b>814 William St.</b>
18. <b>331X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> ANTECEDENT CAUSES <b>Hypertension</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(at)</del> this hospital) attended the deceased from <b>4-14</b> 19 <b>65</b> to <b>4-30</b> 19 <b>65</b> , that <del>(at)</del> (we) last saw the deceased alive on <b>4-30</b> 19 <b>65</b> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Earlie Francis</b> M.D.				23B. DATE SIGNED <b>4-30-65.</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Earlie Francis</b>			23D. ADDRESS M.D. <b>South Baltimore General Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>GLEN HAVEN MEM. PK.</b>	
24D. LOCATION (City, town, or county) (State) <b>GLEN BORNIE, MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>John F. Denny, Jr.</b>		25C. FUNERAL DIRECTOR <b>John F. Denny, Jr.</b> ADDRESS <b>715 LIGHT ST.</b>	

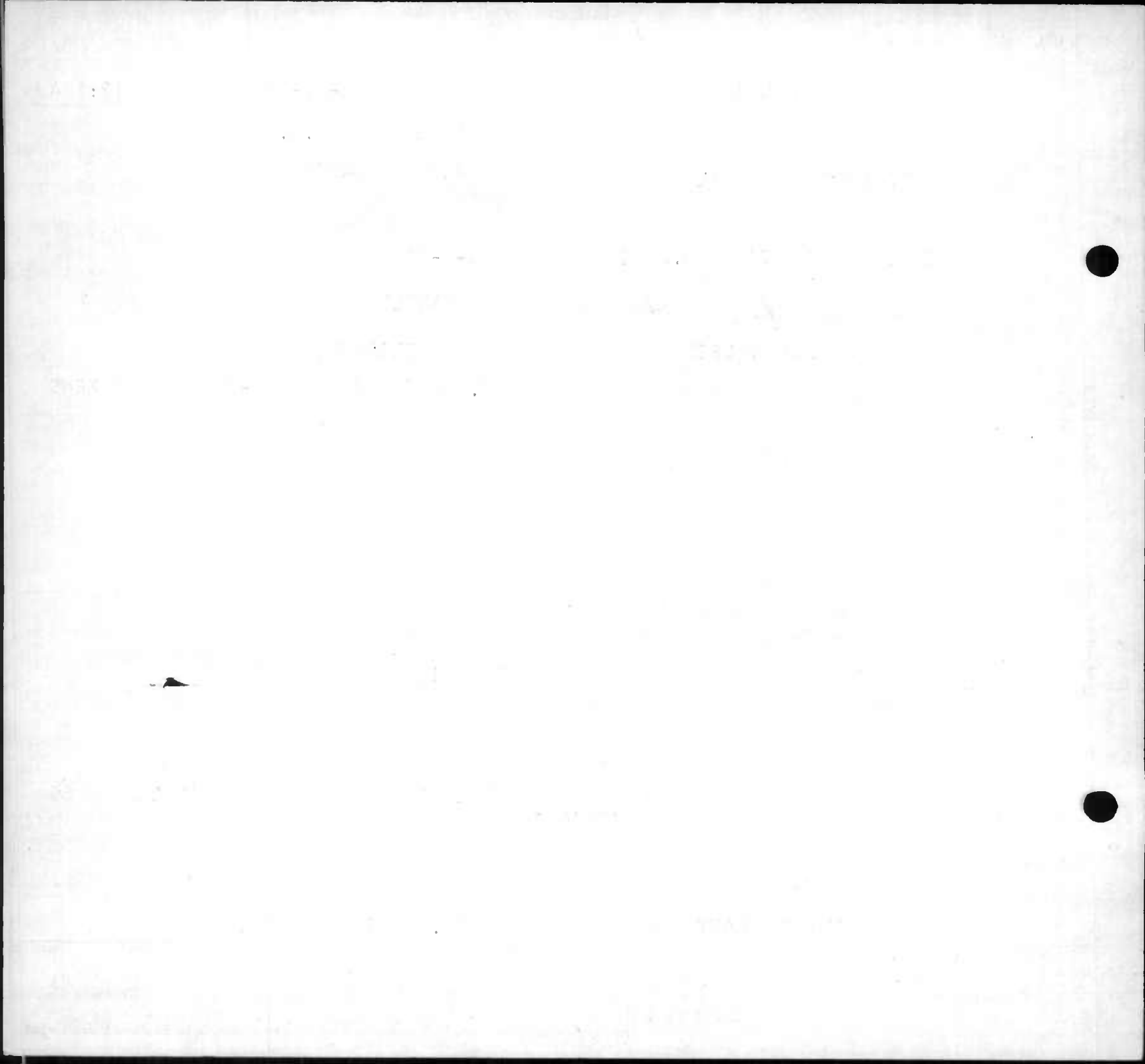




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 65 4685					CERTIFICATE OF DEATH					Registered No. 65 4685						
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH											
MILLER ANNIE					4-28-65					12:15A M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL					A. STATE MARYLAND					B. COUNTY A.A.						
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)					JESSUP, MARYLAND 52-00						
					D. STREET ADDRESS (If rural, give location)											
5. SEX FEMALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED		8. DATE OF BIRTH 8-6-91		9. AGE (In years last birthday) 73		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY Same					11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUDOLPH TAUBER					14. MOTHER'S MAIDEN NAME ELEANORE											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no					16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES RECORDS					ADDRESS -CATON & WILKENS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus					CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) ASCVD DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH						
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from APRIL 22 1965 to APRIL 28 1965, that (I) (we) last saw the deceased alive on APRIL 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE Carmen Fratto					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED 4/28/65						
23C. PHYSICIAN'S NAME (Type) CARMEN FRATTO					23D. ADDRESS ST. AGNES HOSPITAL											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE April 1965					24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park					24D. LOCATION (City, town, or county) (State) Howard Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965					25B. NAME OF REGISTRAR Robert E. Fairbank					25C. FUNERAL DIRECTOR Nelson B. Barksdale					ADDRESS Laurel Md.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE DANIELS, JR.

2. DATE AND HOUR PRONOUNCED DEAD

April 30, 1965

5:25 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4032 Roland Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec. 21, 1924

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Electrician

10B. KIND OF BUSINESS OR INDUSTRY

Steel Plant

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George W. Daniels

14. MOTHER'S MAIDEN NAME

Francis May Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

219 12 7791

17. INFORMANT

ADDRESS

Mildred A. Daniels, 4032 Roland Ave., Balto. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-1-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5 May 65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery Baltimore, Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR


Funeral Home 3631 Falls Rd. Balto. Md.

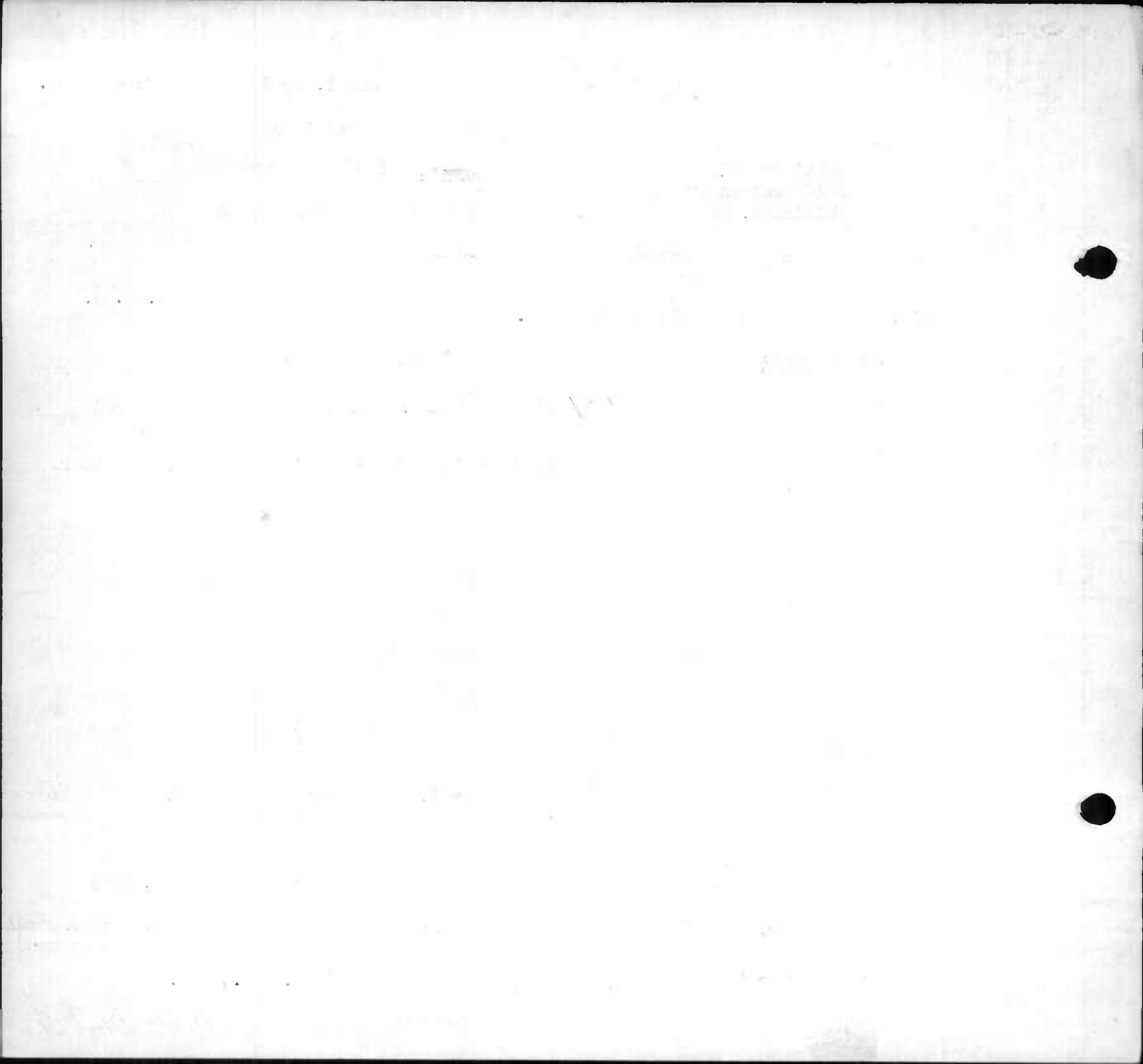
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
65 4687					CERTIFICATE OF DEATH					Registered No. 65 4687									
1. NAME OF DECEASED (Type or Print) <b>Samuel Walter/ Penrod</b>					2. DATE AND HOUR OF DEATH <b>May 1, 1965 7:00 A.M.</b>														
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL: (Middle River) 1300</b> D. STREET ADDRESS (If rural, give location) <b>10 Harrison Avenue #21220</b>														
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>4-11-02</b>		9. AGE (In years last birthday) <b>63</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Riveter</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Mfrgr.</b>					11. BIRTHPLACE (State or foreign country) <b>Ohio</b>									
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					13. FATHER'S NAME <b>George Penrod</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Agnes</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>294/01/7720</b>					17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										CAUSE OF DEATH (A) <b>Intracranial Hemorrhage into Brain Stem 6 Hours</b> DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
										(B) DUE TO									
										(C) DUE TO									
MEDICAL CERTIFICATION										19A. DATE OF OPERATION <b>0</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
										20A. AUTOPSY? (Yes or No) <b>No</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
										21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1965</b> to <b>May 1, 1965</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE 										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>May 1, 1965</b>				
23C. PHYSICIAN'S NAME (Type) <b>Dr. Howard Rathbun</b>										M.D. 23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>1/3/65</b>					24C. NAME OF CEMETERY or CREMATORY <b>Oaklawn</b>					24D. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>					25B. NAME OF REGISTRAR <b>E. F. Baker</b>					25C. FUNERAL DIRECTOR <b>W. B. Baker</b>					ADDRESS <b>W. B. Baker, 1100 N. ...</b>				



LS: 35-87-071

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4688

BIRTH NO.

65 4688

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Anna S. Arturi

2. DATE AND HOUR OF DEATH

May 1, 1965

7:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Avenue #21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

11-29-06

9. AGE (In years  
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Electro Plating

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Latvia

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Theodore Schapow

14. MOTHER'S MAIDEN NAME

Katherine

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

074-16-0347

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 175-01

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) Pseudomucinous Cystadenocarcinoma  
DUE TO

3 Years

(B) Congestive Heart Failure  
DUE TO

2 Months

(C) Hypertension  
DUE TO

6 Months

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 5, 1962 to May 1, 1965  
that (I) (we) lost saw the deceased alive on May 1, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys. ☒

23B. DATE SIGNED

May 1, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

5/1/65

Gardens Faith

Baltimore Co. Md

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 3 1965

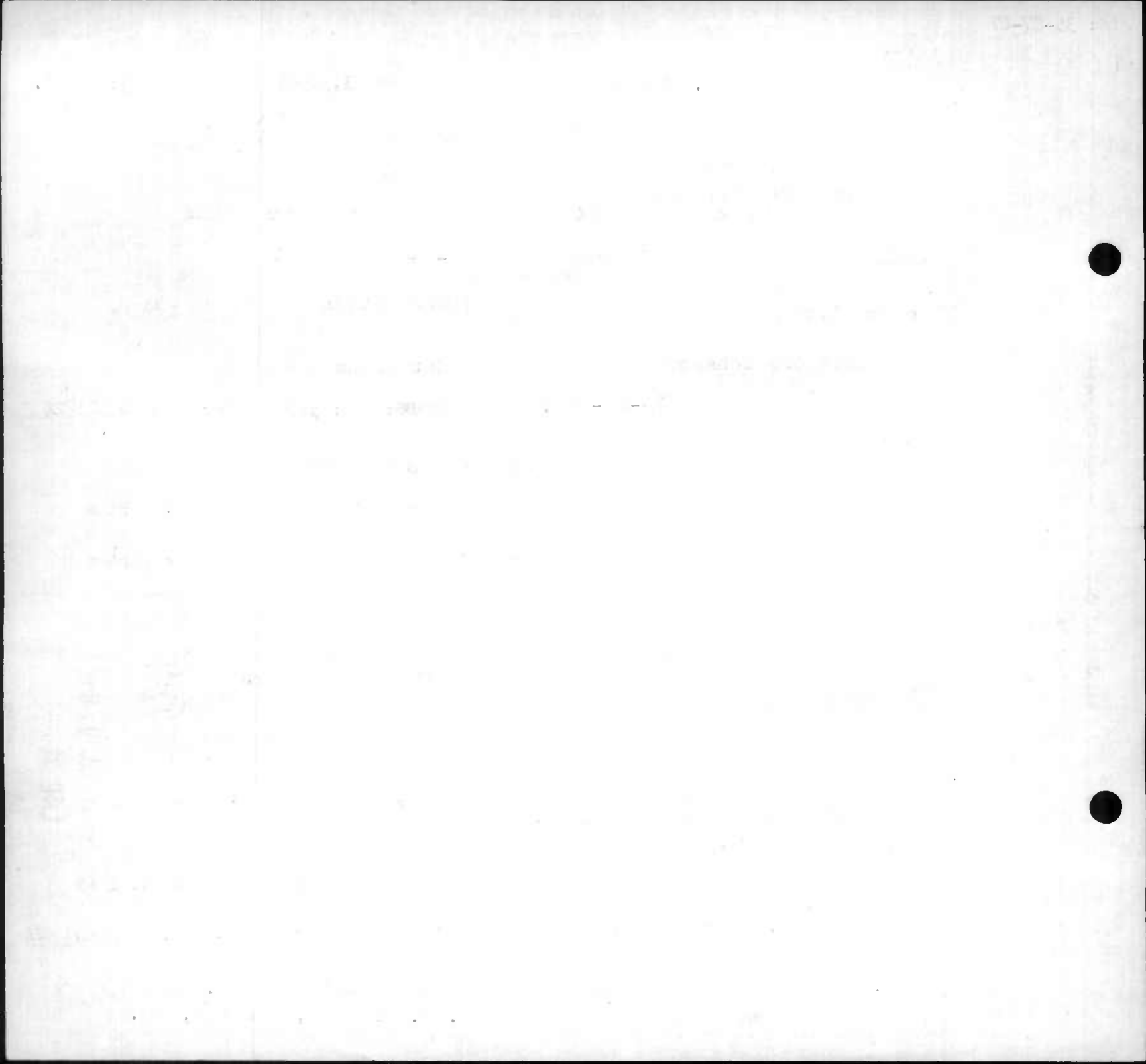
R. E. F. F. F.

W. R. Bradley

Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

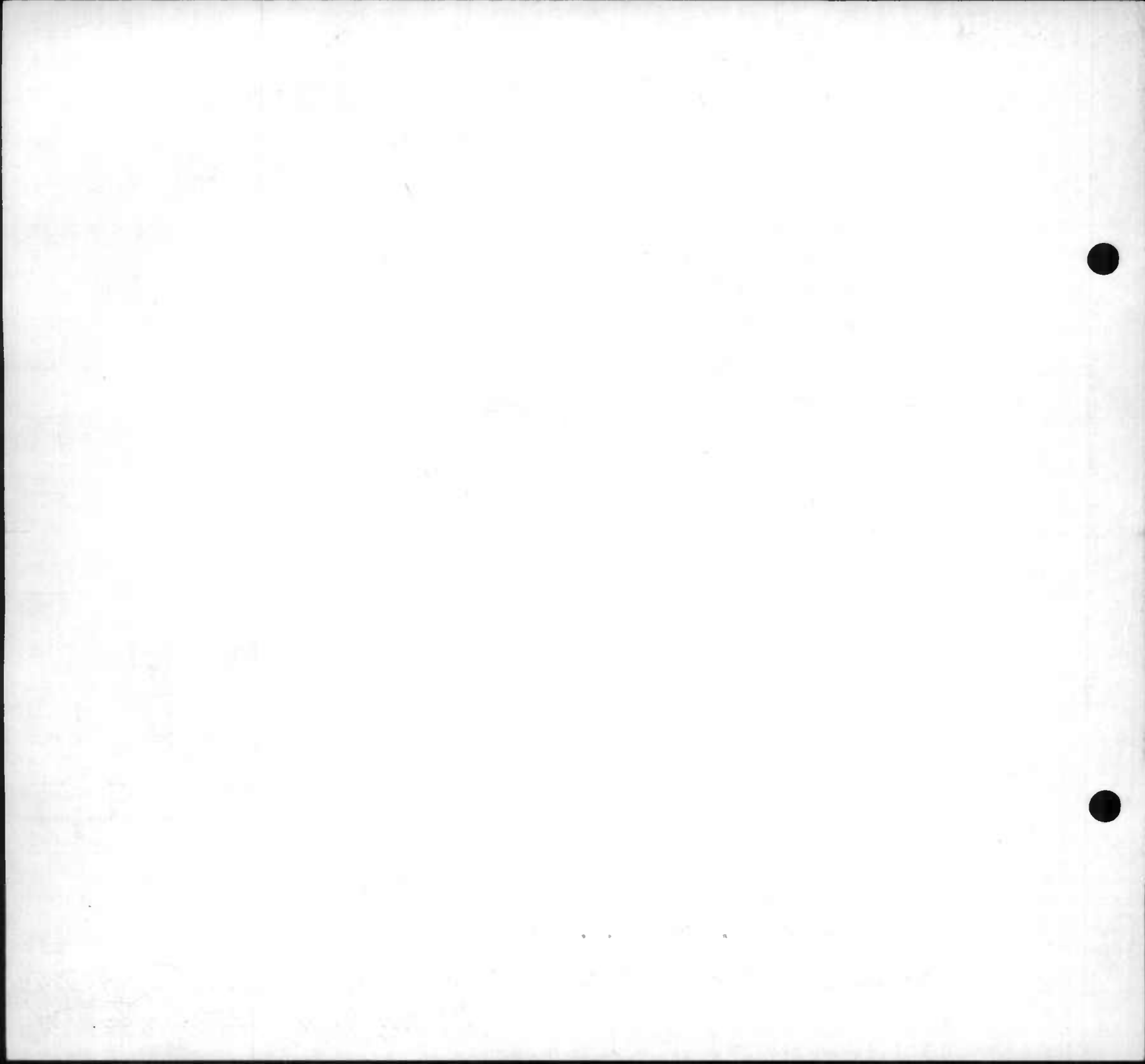




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

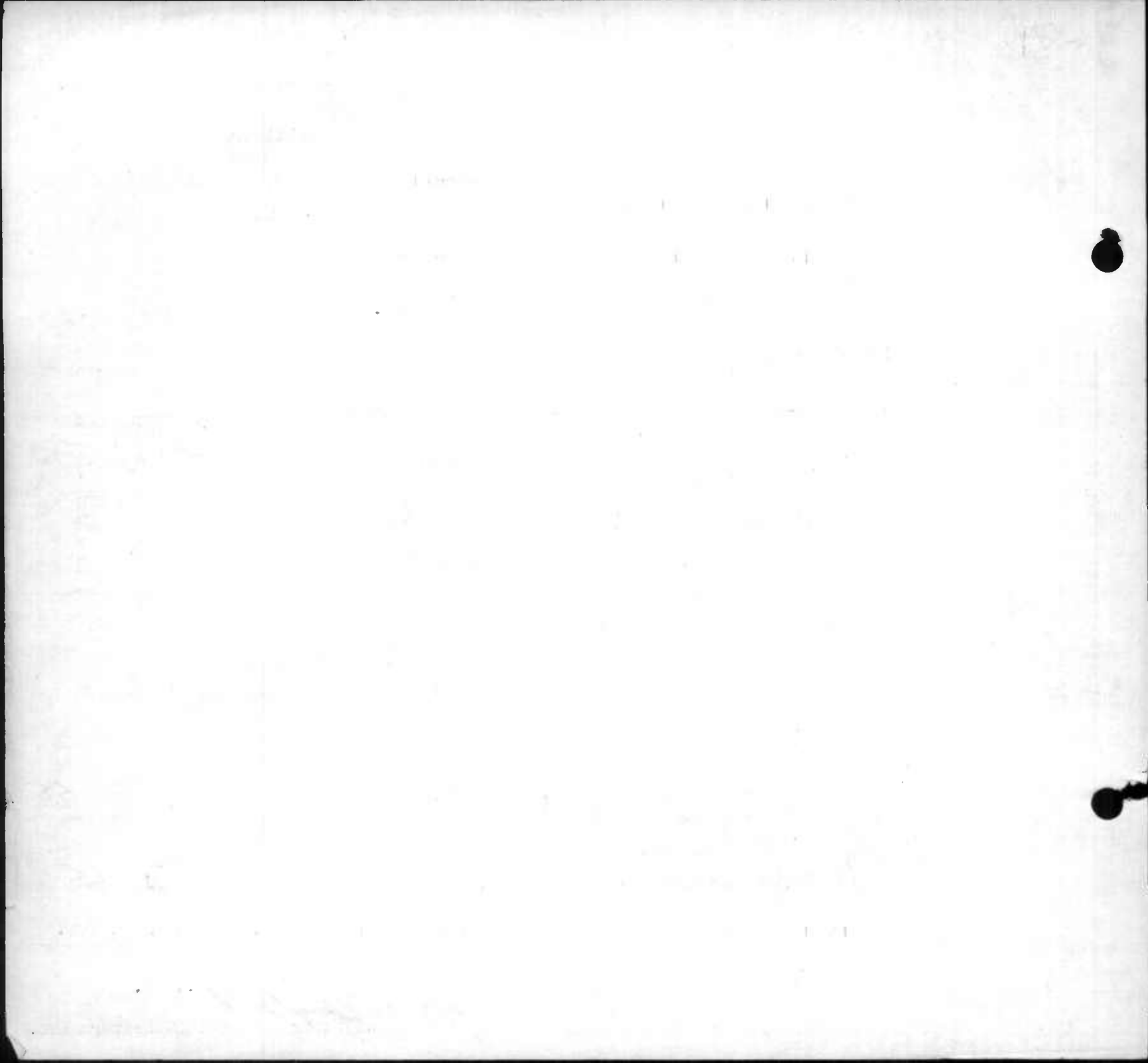
BIRTH NO. 65 4689		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4689	
M.E. CASE NO. SHAFER		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHAFER, Helen MARIE		2. DATE AND HOUR OF DEATH 10 15 A.M. 4/30/65			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived; if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND		A. STATE MARYLAND B. COUNTY Carroll			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) FINISBURG, MARYLAND 5600			
		D. STREET ADDRESS (If rural, give location) West Minister Road			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WID	8. DATE OF BIRTH 7/29/17	9. AGE (In years last birthday) 47	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Edgar T. Logue		14. MOTHER'S MAIDEN NAME Harriet J. Myers		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-0102		17. INFORMANT ADDRESS Patient.	
18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CA of Breast Metastasis DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/27 19 65 to 4/30 19 65, that (I) (we) last saw the deceased alive on 4/30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph J. Mowad		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/30	
23C. PHYSICIAN'S NAME (Type) Joseph J. Mowad M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/65		24C. NAME OF CEMETERY or CREMATORY Pleasant Valley Cemetery Westminster, PA. Md.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

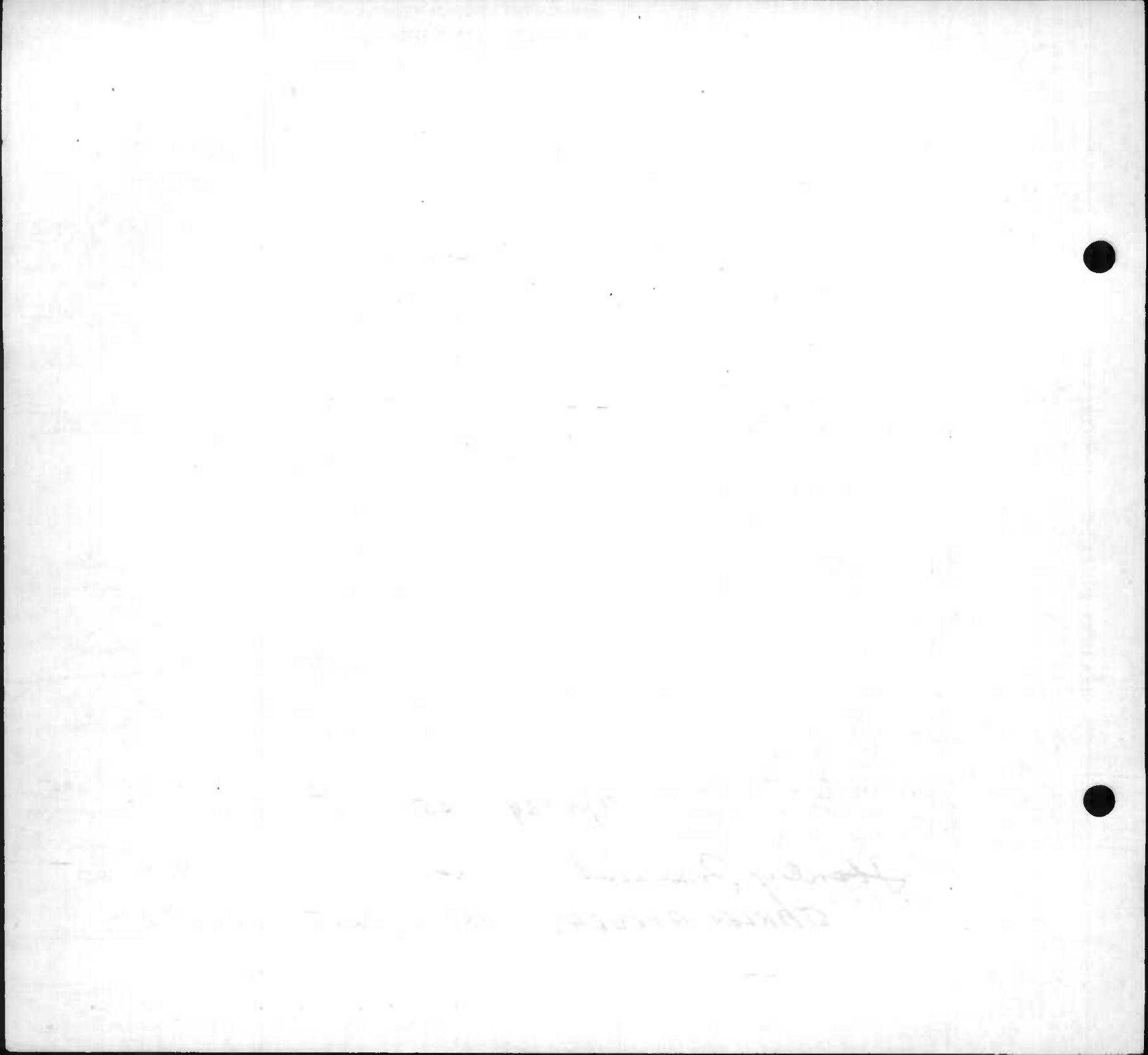
BALTIMORE CITY HEALTH DEPARTMENT				65 4690	
CERTIFICATE OF DEATH				Registered No. 65 4690	
BIRTH NO. 65 4690					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>JOHN FOGLE</b>			2. DATE AND HOUR OF DEATH <b>4-30-65</b> <b>6:30 A.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Essex</b> <b>21</b> D. STREET ADDRESS (If rural, give location) <b>401 TAYLOR AVENUE</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>6-27-67</b>	9. AGE (in years last birthday) <b>97</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>Michael Fogle</b>			14. MOTHER'S MAIDEN NAME <b>Mary ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-36-6652</b>		17. INFORMANT <b>Elizabeth Fogle</b> Same ADDRESS	
18. <b>334 XI</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Brain Syndrome</b> <b>Cerebral vascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>11</b> <b>11</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4.28</b> 19 <b>65</b> to <b>4.30</b> 19 <b>65</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>5.95</b> <b>4.30</b> 19 <b>65</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>W Maxson</b>				23B. DATE SIGNED <b>4.30 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM MAXSON</b>				23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSP., BALTO. 5, MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Washington National Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fogle</b>		25C. FUNERAL DIRECTOR <b>Prudzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

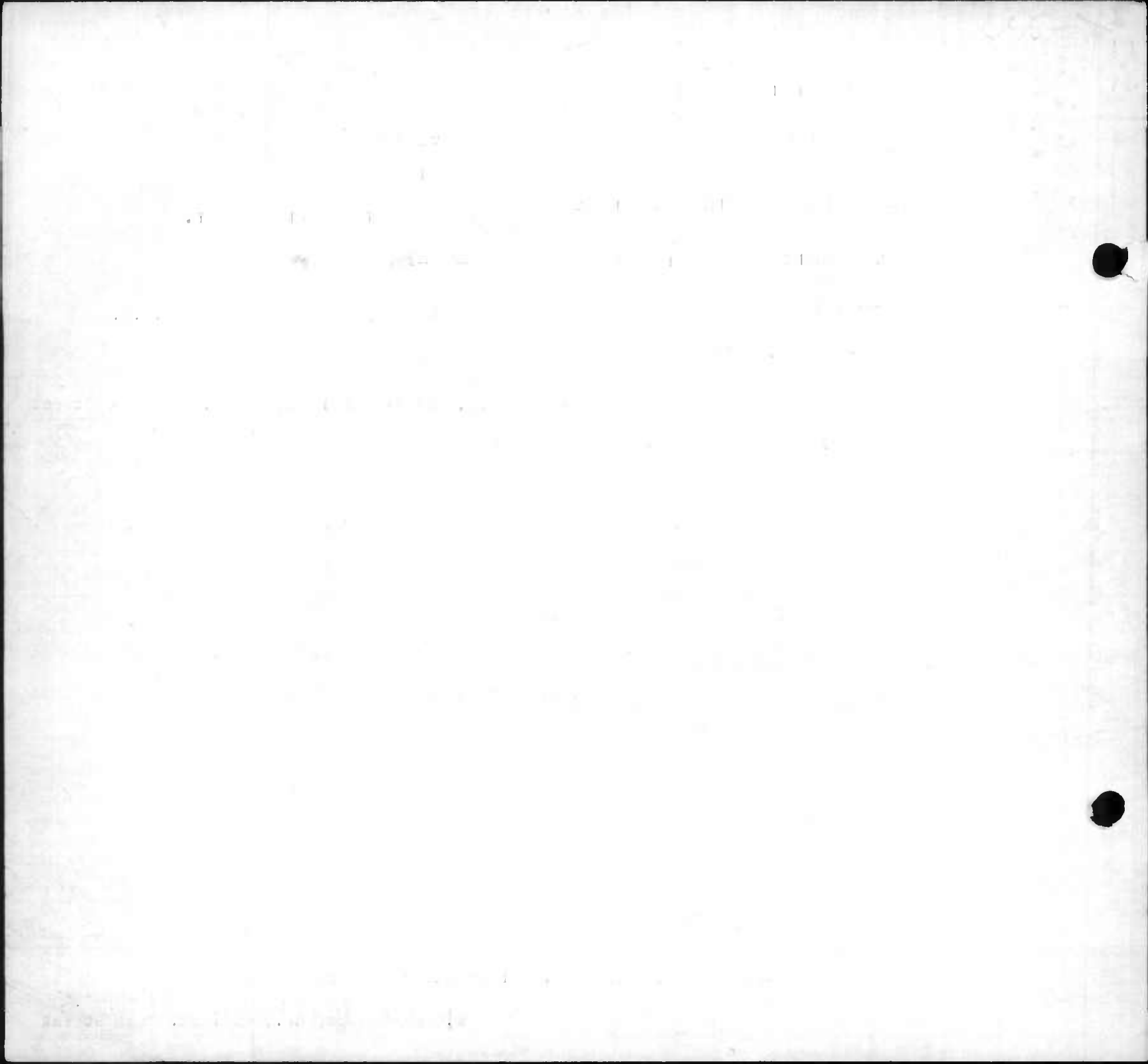
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 4691		65 4691		65 4691	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Vincent J. Krikscuras			April 29, 1965 7:30 P M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital			A. STATE Maryland B. COUNTY 25-43		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore			1810 Spence Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Male	white	Married	9-26-1888	76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tailor		Clothing		Lithuania	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Ignatius Krikscuras			Elizabeth Gapsis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no no		215-09-7596		Miss Lillian Krikscuras 1810 Spence St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)			Interval between ONSET AND DEATH		
ANTECEDENT CAUSES			A. DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Acute myocardial infarction		
II			B. DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			C. DUE TO		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1963 to April 29 1965.					
I (that) (I) (we) last saw the deceased alive on April 29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Stanley Ankudars				4.30.65	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
STANLEY ANKUDARS			1802 W. Boett # Boett 23		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5-3-1965	Holy Redeemer Cem		Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 3 1965		Robert E. Fink		Thomas J. Kenny, Inc. 1600 Hollins St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4692				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4692	
M.E. CASE NO. Akers				2. DATE AND HOUR OF DEATH		5/2/-65 1:09 P.M.			
1. NAME OF DECEASED (Type or Print) DIXIE/ISAAC				3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				THE JOHNS HOPKINS HOSPITAL		MARYLAND			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21231			
						D. STREET ADDRESS (If rural, give location) 1420 EAST BALTIMORE ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
FEMALE	WHITE	WIDOWED	3-13-96	69	Kentucky		U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY					
Housewife									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Henry Clay Akers				Jane Osborn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
				403-10-0562		Mrs. Mollie Stephens, 2302 E. Baltimore Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES				(A) DUE TO				few wh	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO				yrs	
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Pneumonia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 4/2 1965 to 5/2 1965, that (I) (we) last saw the deceased alive on 5/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
J. P. Kokko				5/2/-65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
J. P. Kokko				John Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		5-5-65		New Bridge Church Cemetery		Harrisville, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
MAY 3 1965		Robert E. Johnson		Wm Cook-Brooks, Inc.		1217 St. Paul Street			

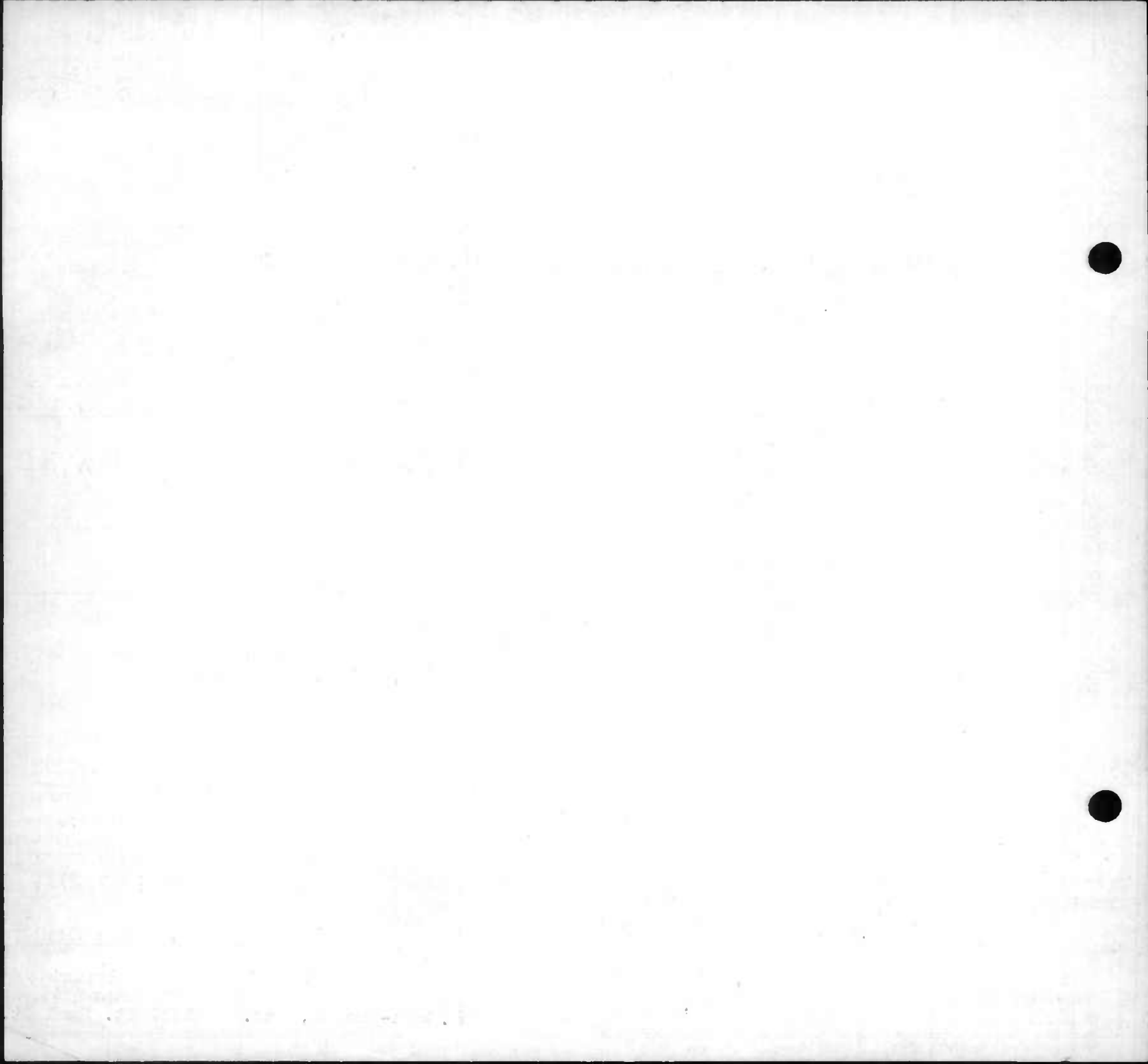




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
65 4693 CERTIFICATE OF DEATH X Registered No. 65 4693											
BIRTH NO. 65 4693											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) JULIAN EUGENE STEPHENSON						2. DATE AND HOUR OF DEATH 5/1/65 1 3 <sup>30</sup> P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE VIRGINIA B. COUNTY V-43					
FULL NAME OF HOSPITAL OR INSTITUTION USPHS HOSPITAL BALTIMORE						C. CITY OR TOWN (If outside city limits, write RURAL and give township) ST AUNTON					
						D. STREET ADDRESS (If rural, give location) RT 4					
5. SEX M		6. RACE W		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MAR		8. DATE OF BIRTH 2/4/32		9. AGE (In years last birthday) 33		10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER						10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JESSE E STEPHENSON						14. MOTHER'S MAIDEN NAME NORA E ERVINE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) KOREAN						16. SOCIAL SECURITY NO.		17. INFORMANT CLAUDIA B. STEPHENSON			
								ADDRESS ROUTE 4 STAUNTON, VA			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.						CAUSE OF DEATH HODGKINS DISEASE				INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS	
						(A) DUE TO					
						(B) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>HE</u> (this hospital) attended the deceased from <u>APR 5</u> 19 <u>65</u> to <u>MAY 1</u> 19 <u>65</u> , that <u>HE</u> (we) last saw the deceased alive on <u>MAY 1</u> 19 <u>65</u> and that in <u>MY</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>HE</u> (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>James E. Taylor, Jr.</i>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED MAY 2, 1965			
23C. PHYSICIAN'S NAME (Type) JAMES E. TAYLOR, JR.						23D. ADDRESS USPHS HOSPITAL, BALTIMORE					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE May 2, 1965		24C. NAME OF CEMETERY OR CREMATORY Warm Springs Cemetery				24D. LOCATION (City, town, or county) (State) Hot Springs Virginia			
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1965				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.				25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc.			
								ADDRESS 1217 St. Paul St.			



1  
5-356

BALTIMORE CITY HEALTH DEPARTMENT

65 4694

BIRTH NO.

65 4694

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM S. STONER

2. DATE AND HOUR PRONOUNCED DEAD

May 2, 1965

3:40 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5819 Benton Heights Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

April 26, 1899

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Machinist (ret'd)

10B. KIND OF BUSINESS OR INDUSTRY

Glen L. Martin

11. BIRTHPLACE (State or foreign country)

Saloma, Penna.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry M. Stoner

14. MOTHER'S MAIDEN NAME

Erma Harry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Dr. Charles Stoner

Altoona, Penna.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Brätenecker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

May 2, 1965

23C. NAME of CEMETERY or CREMATORY

Grandview Cemetery

23D. LOCATION

(City, town, or county)

Altoona

(State)

Penna.

24A. DATE REC'D BY HEALTH DEPT.

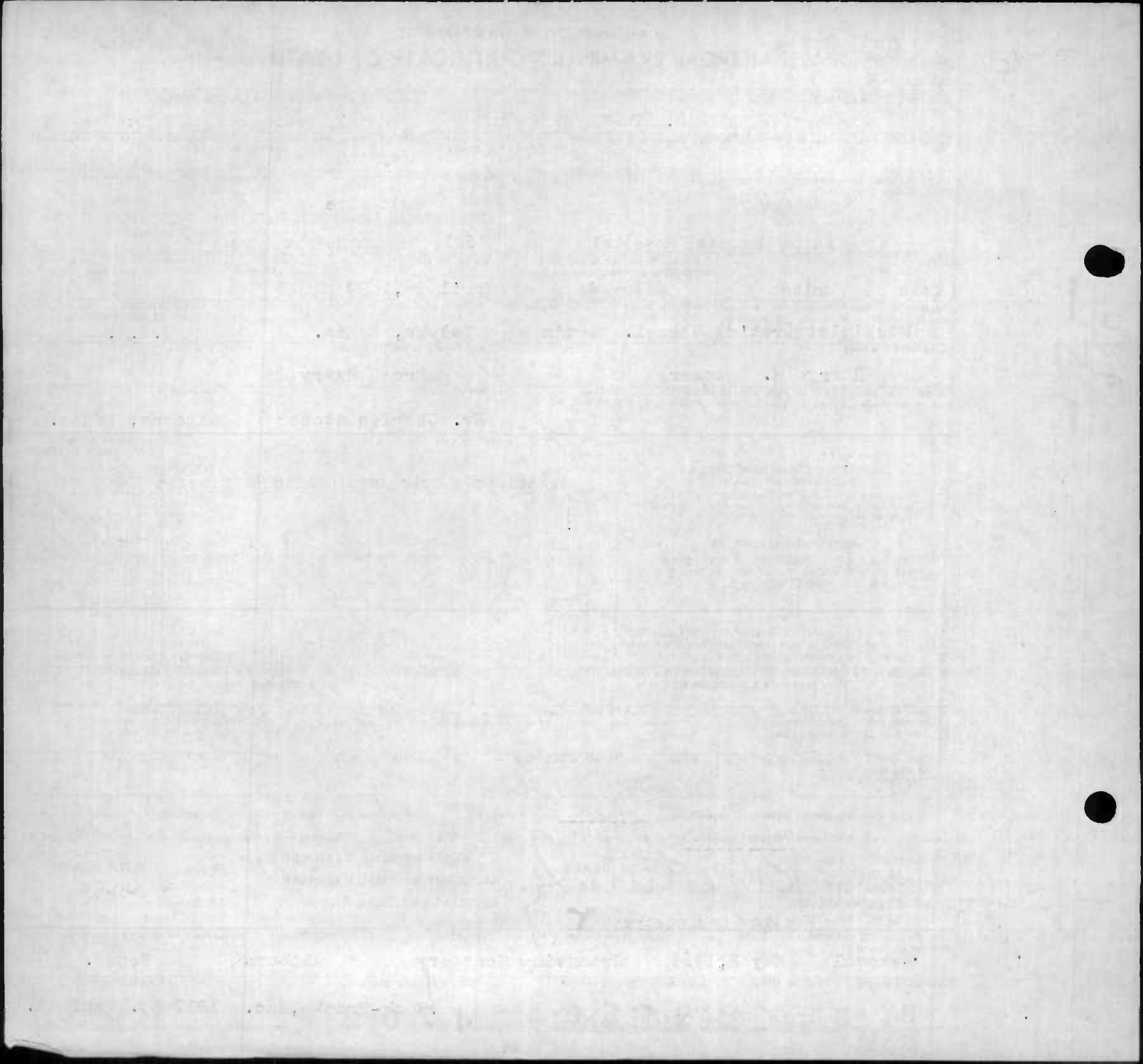
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 3 1965

Wm Cook-Brooks, Inc. 1217 St. Paul St.



LS: 41-67-64

65 4695

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 4695

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Emily Pruger

2. DATE AND HOUR OF DEATH

April 30, 1965

6:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1808 North Calvert Street #21202

5. SEX

Female White

6. RACE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

8-6-24

9. AGE (In years  
last birthday)

40

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18. 141.9 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Respiratory Obstruction

(B) DUE TO

Carcinoma of Tongue

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 23, 1964 to April 30, 1965, that (I) (we) last saw the deceased alive on April 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Howard Rathbun*

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

April 30, 1965

23C. PHYSICIAN'S NAME (Type)

Dr. Howard Rathbun

23D. ADDRESS

M.D. 4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

May 2, 65

24C. NAME of CEMETERY or CREMATORY

Overlook Cemetery

24D. LOCATION

(City, town, or county)

Leaksville, N. Car.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

25B. NAME OF REGISTRAR

*Robert E. Fairley*

25C. FUNERAL DIRECTOR

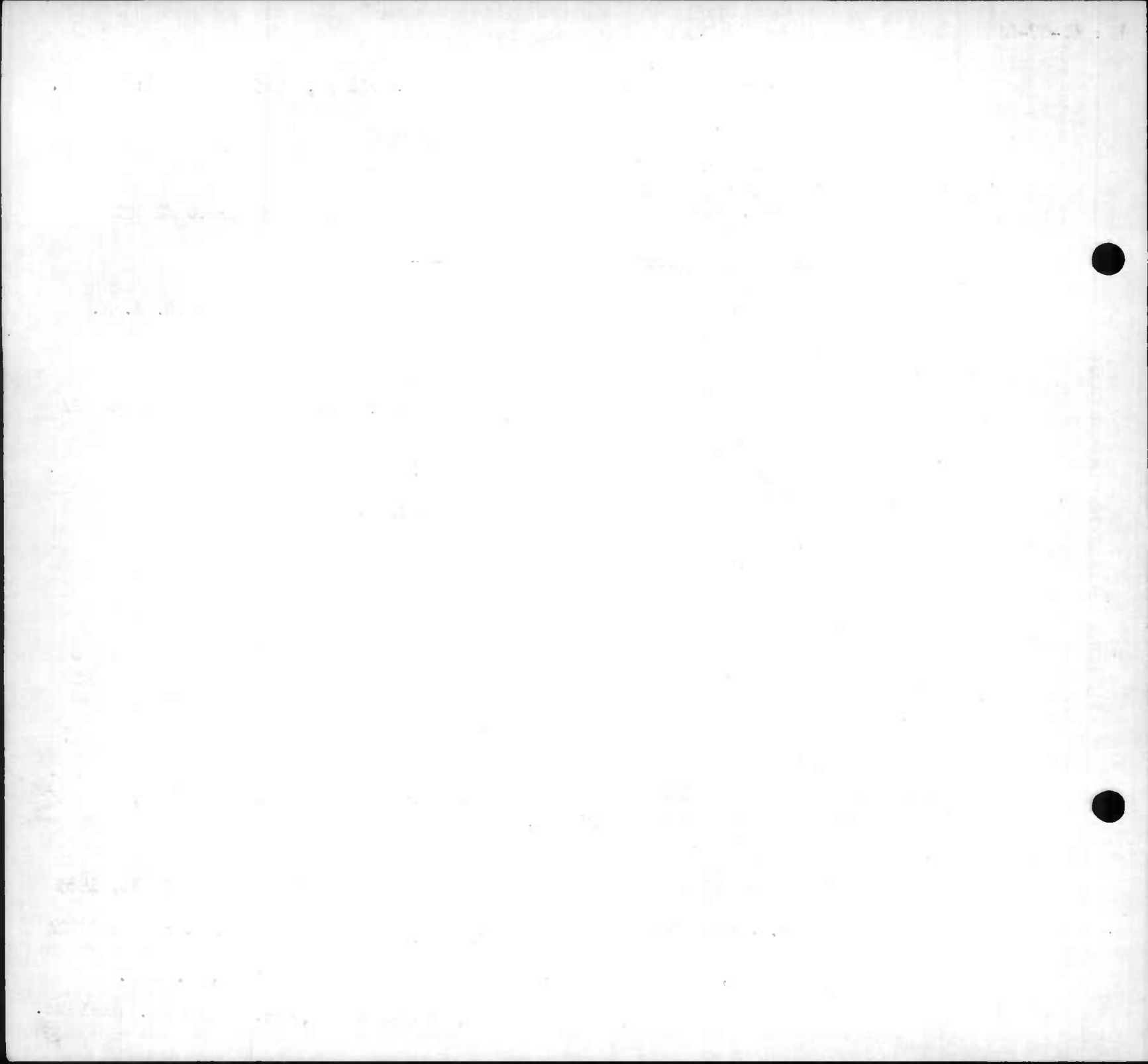
Wm Cook-Brooks, Inc.

ADDRESS

1217 St. Paul St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



65 4696

BALTIMORE CITY HEALTH DEPARTMENT

65 4696

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM TOWNSEND LYONS

2. DATE AND HOUR PRONOUNCED DEAD

April 29, 1965 1:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mt. Royal Hotel

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Mt. Royal Hotel

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
widowed

8. DATE OF BIRTH

Feb. 6, 1902

9. AGE (In years  
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Md. Labor Press

11. BIRTHPLACE (State or foreign country)

Atlantic City, New Jersey

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John J. Lyons

14. MOTHER'S MAIDEN NAME

Marguerite Polsley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL  
SECURITY NO.

382-10-3514

17. INFORMANT

ADDRESS

Robert R. Lyons, 360 14th St, N.W. CHARLOTTESVILLE Va

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4/29/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-4-65

23C. NAME of CEMETERY or CREMATORY

Arlington National

23D. LOCATION

(City, town, or county)

(State)

Arlington, Virginia

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert E. Fickens

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc., 1217 St. Paul Street



VALLEY FORGE



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 4697</span>	
BIRTH NO. <span style="float: right;">65 4697</span>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WINKLER MISSCELECTA E.</b>		2. DATE AND HOUR OF DEATH <b>5-1-1965 4-15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home and Hospital Baltimore, 31, Md</b>		A. STATE <b>Maryland</b> B. COUNTY <b>12-05</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore, 01</b>			
		D. STREET ADDRESS (If rural, give location) <b>25 W. North Avenue</b>			
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>1-16-12</b>	9. AGE (In years last birthday) <b>53 yrs.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales-Clerk, G.C. Murphy</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles, Winkler</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Wilson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>2214-16-2616</b>		17. INFORMANT ADDRESS <b>Tramm, George (Brother) 25 W. North Av. Balt-01</b>	
18. <b>271X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Pulmonary Emphysema</b> DUE TO (B) <b>Chronic cor pulmonale</b> DUE TO (C) <b>Bronchial asthma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>since childhood</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>14-25-1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tracheostomy for pulmonary emphysema</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>	
21C. WHERE DID INJURY OCCUR? <b>-</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>-</b>		22. I certify that (I) (this hospital) attended the deceased from <b>4-25-1965</b> 19 to <b>5-1-1965</b> 19, that (I) (we) last saw the deceased alive on <b>5-1-1965</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Kishor C. Mehta</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-1-1965</b>	
23C. PHYSICIAN'S NAME (Typo) <b>KISHOR. C. MEHTA</b>		23D. ADDRESS M.D. <b>Church Home and Hospital Baltimore 31, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24B. DATE <b>5-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Odd Fellows Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Elk Garden, W.Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>W. Cook Brooks Inc.</b>		ADDRESS <b>1217 St. Paul Street/</b>	

Admission 21  
22 W. North Street

Admission 21  
22 W. North Street

Female & White

1-16-15

Charles, Winkler

Marjorie

Ellen Wilson

Charles, Winkler

Thomas (George) Wilson

Primrose & Elizabeth

Chronic cor pulmonale

Bleeding asthma

4-22-1922  
Admission 21  
22 W. North Street

2-1-1922  
4-22-1922

KISHOR C. MEHTA  
KISHOR C. MEHTA

Chronic cor pulmonale  
Bleeding asthma

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4698</b>	
BIRTH NO. <b>65 4698</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MARY Alice Leschofsky</b>		2. DATE AND HOUR OF DEATH <b>April 30, 1965 10:45 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE <b>Maryland</b>		B. COUNTY <b>9-05</b>	
<b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21218</b>			
		D. STREET ADDRESS (If rural, give location) <b>920 Montpelier St.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec 23, 1906</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frank Lantz</b>		14. MOTHER'S MAIDEN NAME <b>Laura Betz</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-20-6967</b>		17. INFORMANT ADDRESS <b>John F. Leschofsky, 920 Montpelier St. 21218</b>	
18. <b>420.1 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<b>Acute Myocardial Infarction</b>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Arteriosclerotic Cardiovascular Disease</b>			
ANTECEDENT CAUSES		DUE TO (C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 9 1965</b> to <b>April 30 1965</b> , that (I) (we) last saw the deceased alive on <b>April 30 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>L.S. Tilley</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 30, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>L.G. Tilley</b>		23D. ADDRESS M.D. <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-3-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks, Inc., 1217 St. Paul Street</b>	

L. J. Tilly  
L. J. Tilly

April 30  
April 30

No

April 30

Ward on Brown, May 1

Four Points

W W W

Ward on Brown

Ward on Brown

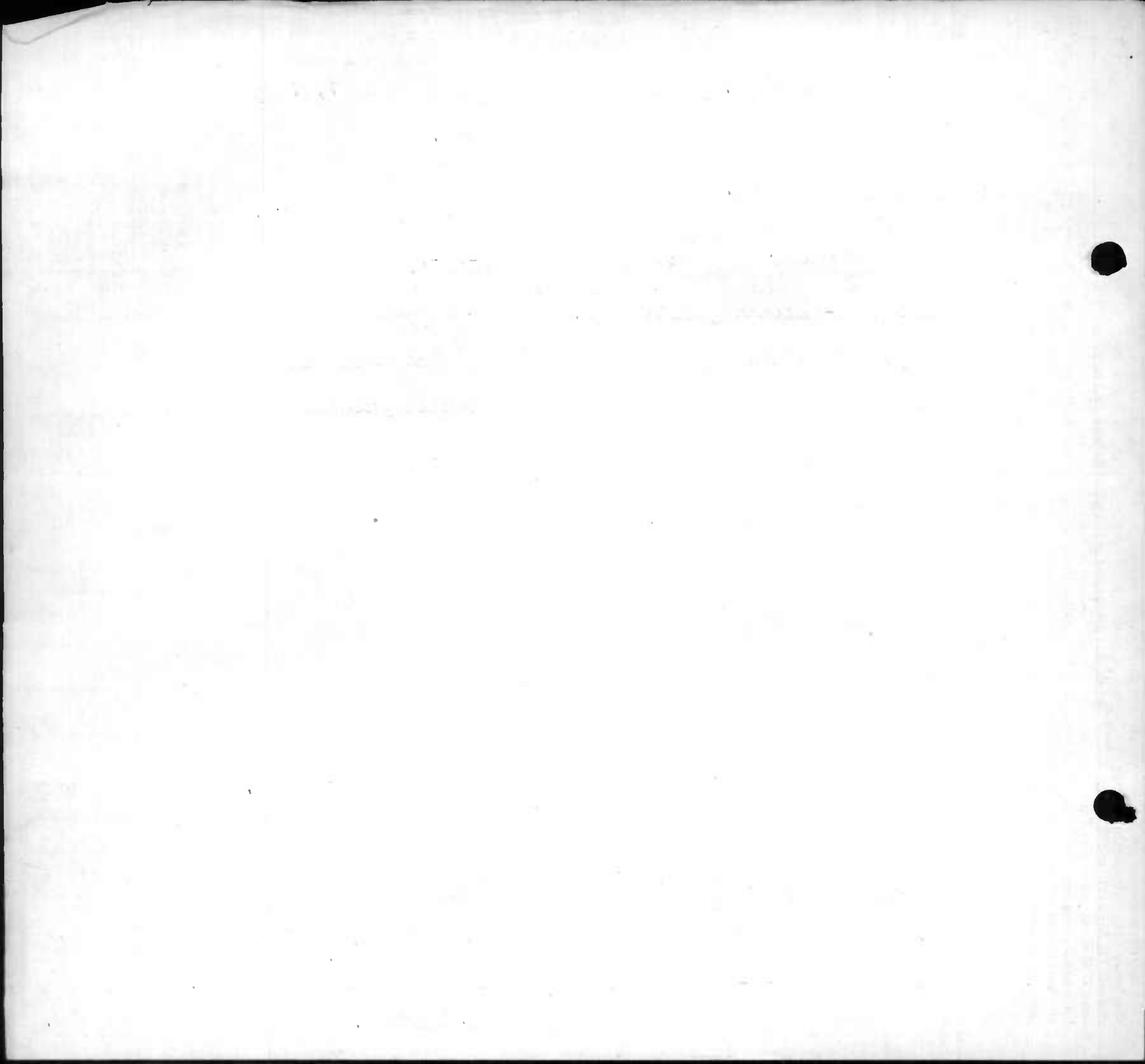
Ward on Brown

Ward on Brown

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

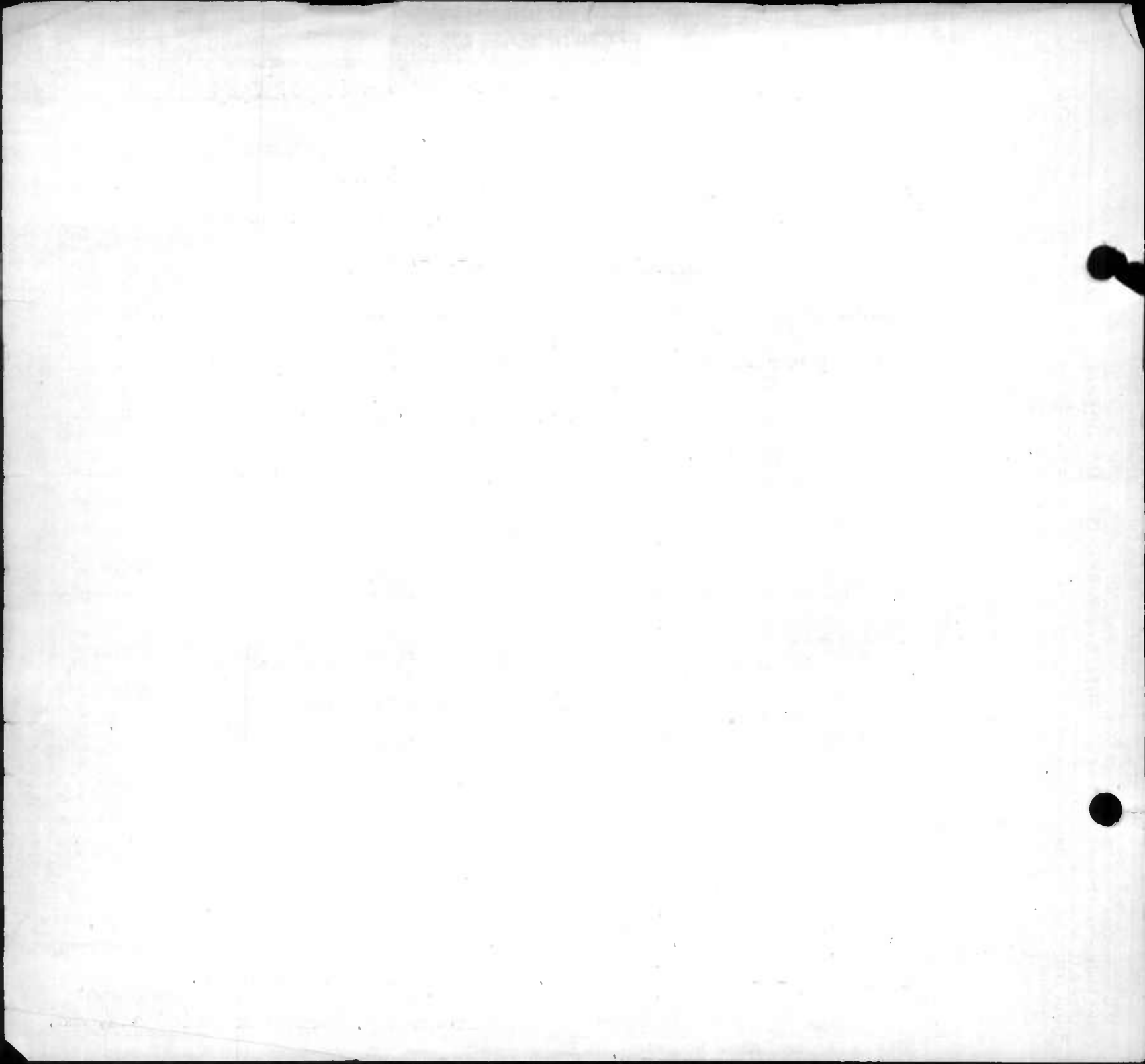
BIRTH NO. 65 4699				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4699	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Paul O. Guidice</b>				2. DATE AND HOUR OF DEATH <b>May 1, 1965</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-44</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3107 Gibbons Ave.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>3107 Gibbons Ave.</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>9-15-1901</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist-Western Electric Co.</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edward Guidice</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Ochse</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Louise Guidice</b> ADDRESS <b>same</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) <b>Squamous Cell Carcinoma of lung</b>			CAUSE OF DEATH <b>(A) Squamous Cell Carcinoma of lung</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Malnutrition; hypotension; arteriosclerosis</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 5</b> 19 <b>65</b> to <b>May 1</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 1</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>H. V. Harbold</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARBOLD</b>				23D. ADDRESS M.D. <b>4706 Harford Road Baltimore, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>5-5-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>		ADDRESS <b>Baltimore, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4700</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4700</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">George Goemmer</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 30, 1965</span> <span style="float: right;">M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">617 East 36th Street</span>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">9-03</span>			
5. SEX <span style="font-size: 1.2em;">male</span>		6. RACE <span style="font-size: 1.2em;">white</span>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">married</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">8-10-1894</span>	
9. AGE (In years last birthday) <span style="font-size: 1.2em;">70</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mechanic</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Carl Goemmer</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Marie Lenz</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">220305493</span>		17. INFORMANT <span style="font-size: 1.2em;">Emma M. Goemmer</span>		ADDRESS <span style="font-size: 1.2em;">same</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">163X I</span>  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Carcinoma of Lung</span> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">6 mos.</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">October 1964</span> to <span style="font-size: 1.2em;">4-30 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-30 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">W. K. Wong</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5-1-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">WYMAN K. WONG</span>				23D. ADDRESS <span style="font-size: 1.2em;">2801 Belair Rd Baltimore Md</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">burial</span>		24B. DATE <span style="font-size: 1.2em;">5-3-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Jerusalem Lutheran Cem</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 3 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leobard J. Ruck Inc</span>		ADDRESS <span style="font-size: 1.2em;">Baltimore, Md.</span>	

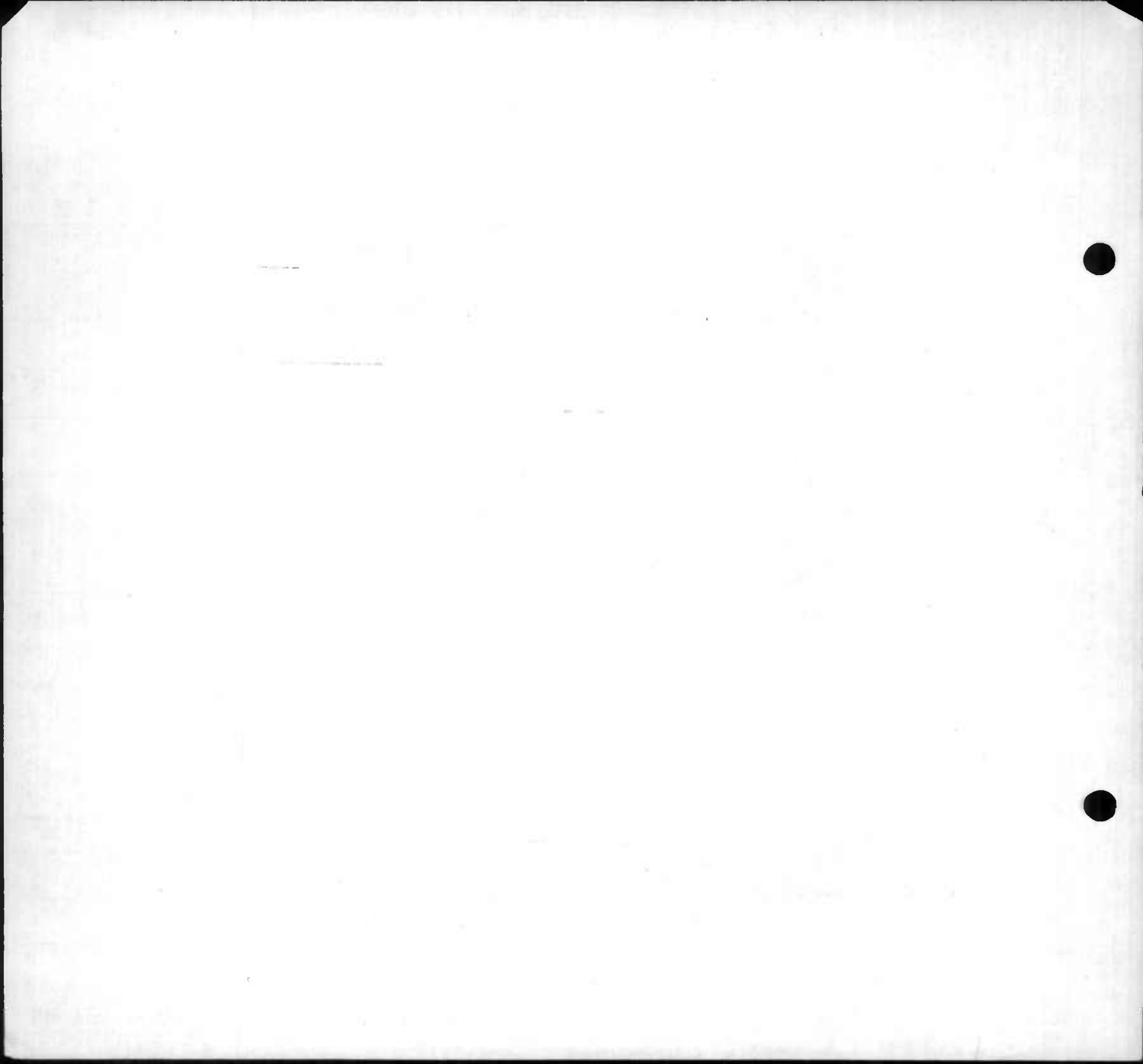




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
65 4701					65 4701						
BIRTH NO.					REGISTERED NO.						
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <u>Mario Nortrup</u>					2. DATE AND HOUR OF DEATH <u>5/1/65</u> <u>12:20</u> M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp</u>					A. STATE <u>Maryland</u> B. COUNTY <u>27-03</u>						
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>						
					D. STREET ADDRESS (If rural, give location) <u>4900 Waltham Ave</u>						
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>11-12-98</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife &amp; Ret. School Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George J. Bing</u>					14. MOTHER'S MAIDEN NAME <u>Eva Dannis Ditman</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-46-7190</u>		17. INFORMANT <u>Husband - Charles</u>		ADDRESS <u>Same</u>			
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <u>Acute myocardial Infarction</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <u>hrs ?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> 19 <u>65</u> to <u>5/1</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>5/1</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Marian L. Cohen</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>5/1/65</u>			
23C. PHYSICIAN'S NAME (Type) <u>Marian L. Cohen</u>					23D. ADDRESS M.D. <u>Union Memorial Hospital</u>						
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>5/4/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fairhead</u>			25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>			ADDRESS <u>5305 Harford Road #14</u>		



BIRTH NO. 65 4702

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ORSON A. ALDRICH

2. DATE AND HOUR PRONOUNCED DEAD

5-2-65

9:15 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1117 Gorsuch Avenue 21218

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Feb. 28, 1894

9. AGE (In years  
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Milford, New York

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Wren Aldrich

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

218-07-3323 Mrs. Iva D. Aldrich

17. INFORMANT

ADDRESS

same

18.

527.1 14

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Congestive heart failure  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Pulmonary emphysema  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-2-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/5/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 3 1965

24B. NAME OF REGISTRAR

Robert E. [unclear]

24C. FUNERAL DIRECTOR

Leonard J. [unclear]

ADDRESS

Ruck Inc 5305 Harford Road #14

WALLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 4703

BIRTH NO.

65 4703

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPHINE M. MAGGIO.

2. DATE AND HOUR OF DEATH

4. 30. '65.

2. 50 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

CHURCH HOME & HOSPITAL.

BALTIMORE, 31. 4D.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

BALTIMORE.

D. STREET ADDRESS

(If rural, give location)

250 S. Dallas Street.

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
WIDOWED.

8. DATE OF BIRTH

12. 7. '89.

9. AGE (In years last birthday)

75 yrs.

If Under 1 Yr.

If Under 24 Hrs.

Months: Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

R. JOHN CURCI

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, na or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None.

17. INFORMANT

Angeline Maggio.

ADDRESS

236 S. Eden Street, Balt.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Abscess in gluteal region

(B) DUE TO

Probable diabetes.

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4. 22. '68.

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Abscess lt. buttock

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4. 18. '65 to 4. 30. 1965, that (I) (we) last saw the deceased alive on 4. 30. 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Basu

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4. 30. '65.

23C. PHYSICIAN'S NAME (Type)

Dr. PARK N. Basu.

M.D.

23D. ADDRESS

Church Home & Hospital, Baltimore.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

5/4/65

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER CEMETERY

24D. LOCATION

BALTIMORE, MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

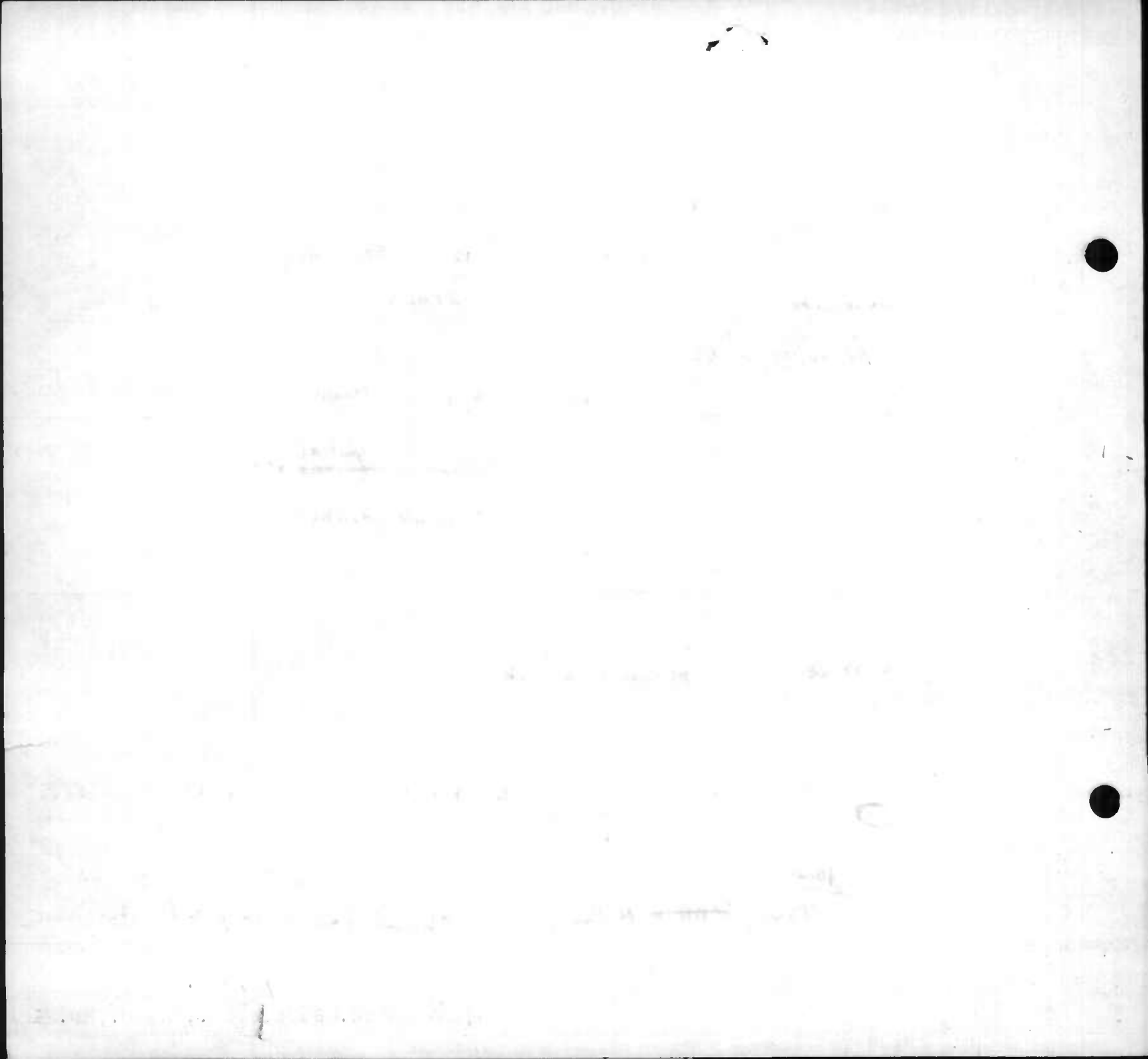
ADDRESS

MAY 3 1965

Robert E. Farley

LEONARD J. RUCK, INC., BALTO., MD. 2121

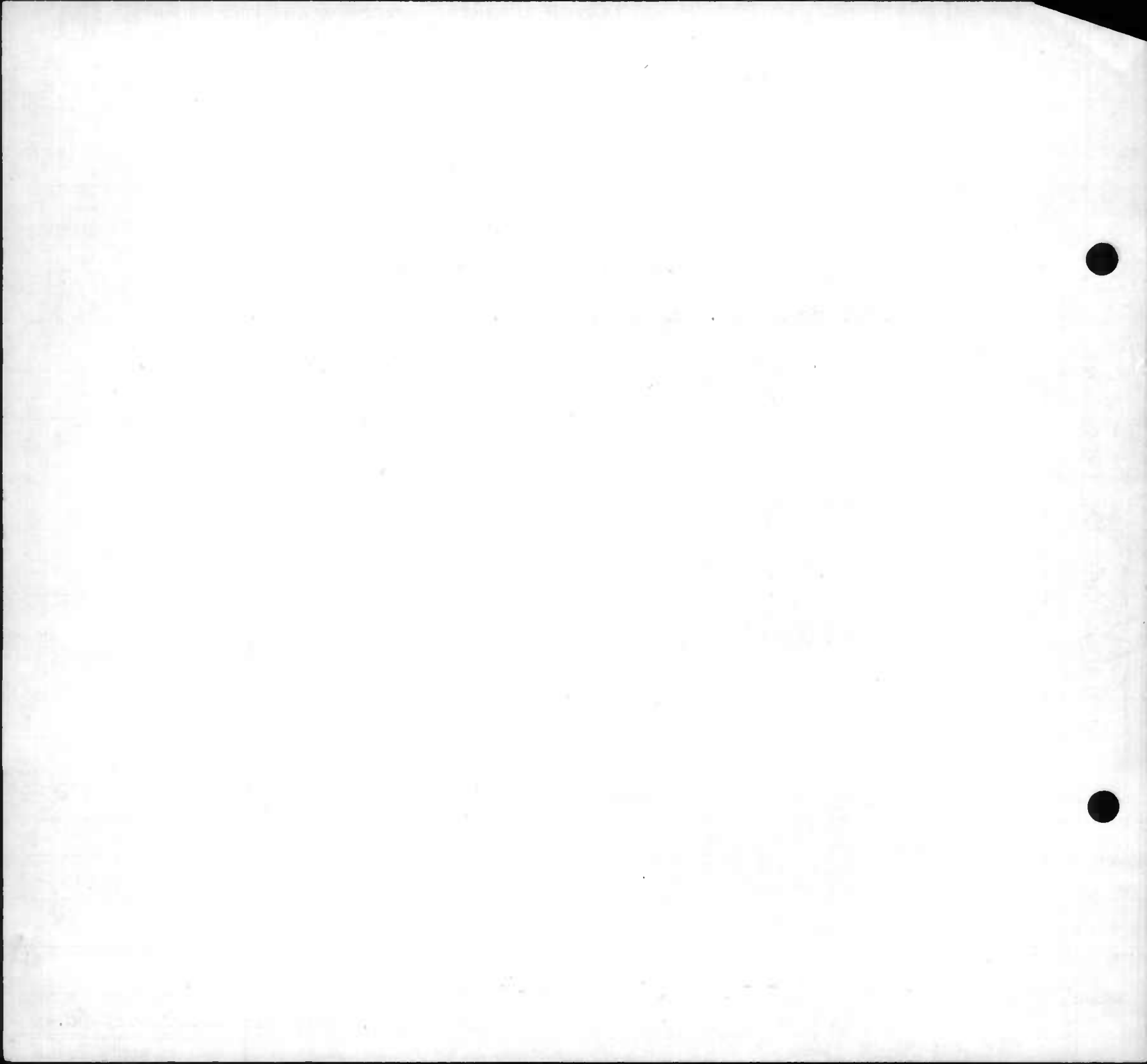
VS-150 REV. 12/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

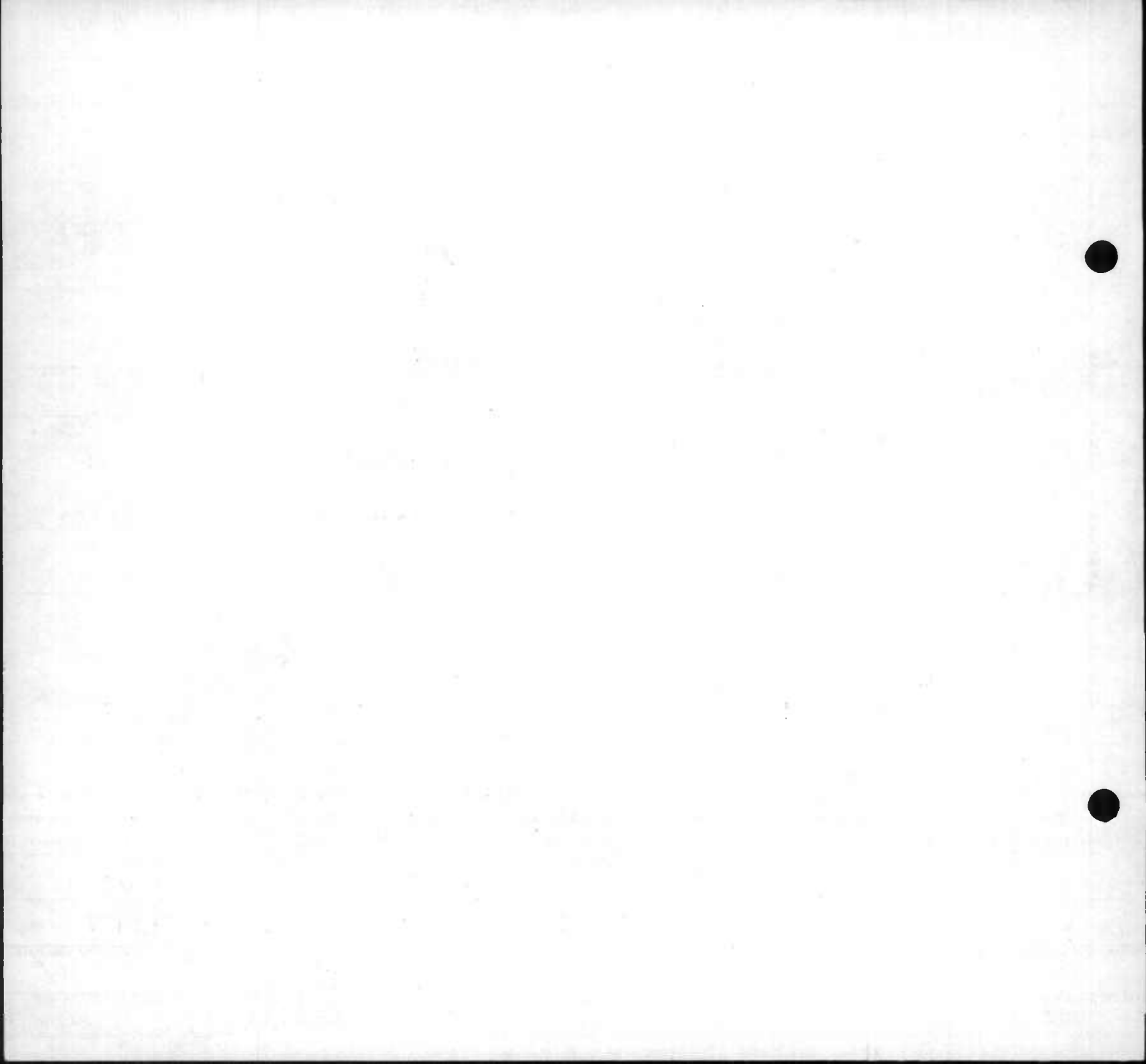
BALTIMORE CITY HEALTH DEPARTMENT										
65 4704 CERTIFICATE OF DEATH					Registered No. 65 4704					
BIRTH NO. 65 4704					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>Edward T. Voss</u>					2. DATE AND HOUR OF DEATH <u>May 2, 1965</u> <u>10:55 P.M.</u>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland Gen. Hospital</u>					A. STATE <u>Maryland</u>					
					B. COUNTY <u>26-01</u>					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>					
					D. STREET ADDRESS (If rural, give location) <u>4217 Kolt Ave.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED/NEVER MARRIED <u>MARRIED</u>		8. DATE OF BIRTH <u>9/15/00</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Warehouse Supvr.</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, Md.</u>			11. BIRTHPLACE (State or foreign country) <u>USA</u>		
13. FATHER'S NAME <u>Ernest R. Voss</u>					14. MOTHER'S MAIDEN NAME <u>Katherine Graley</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW I</u>					16. SOCIAL SECURITY NO. <u>216054253</u>		17. INFORMANT <u>Isabel E. Voss - same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u> <u>RENAL SHOTDOWN</u>					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>April 4</u> 19 <u>65</u> to <u>May 2</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>10:55 p.m.</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Leonard J. Ruck</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>May 2, 1965</u>		
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>5-6-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u>			ADDRESS <u>Baltimore, Md.</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

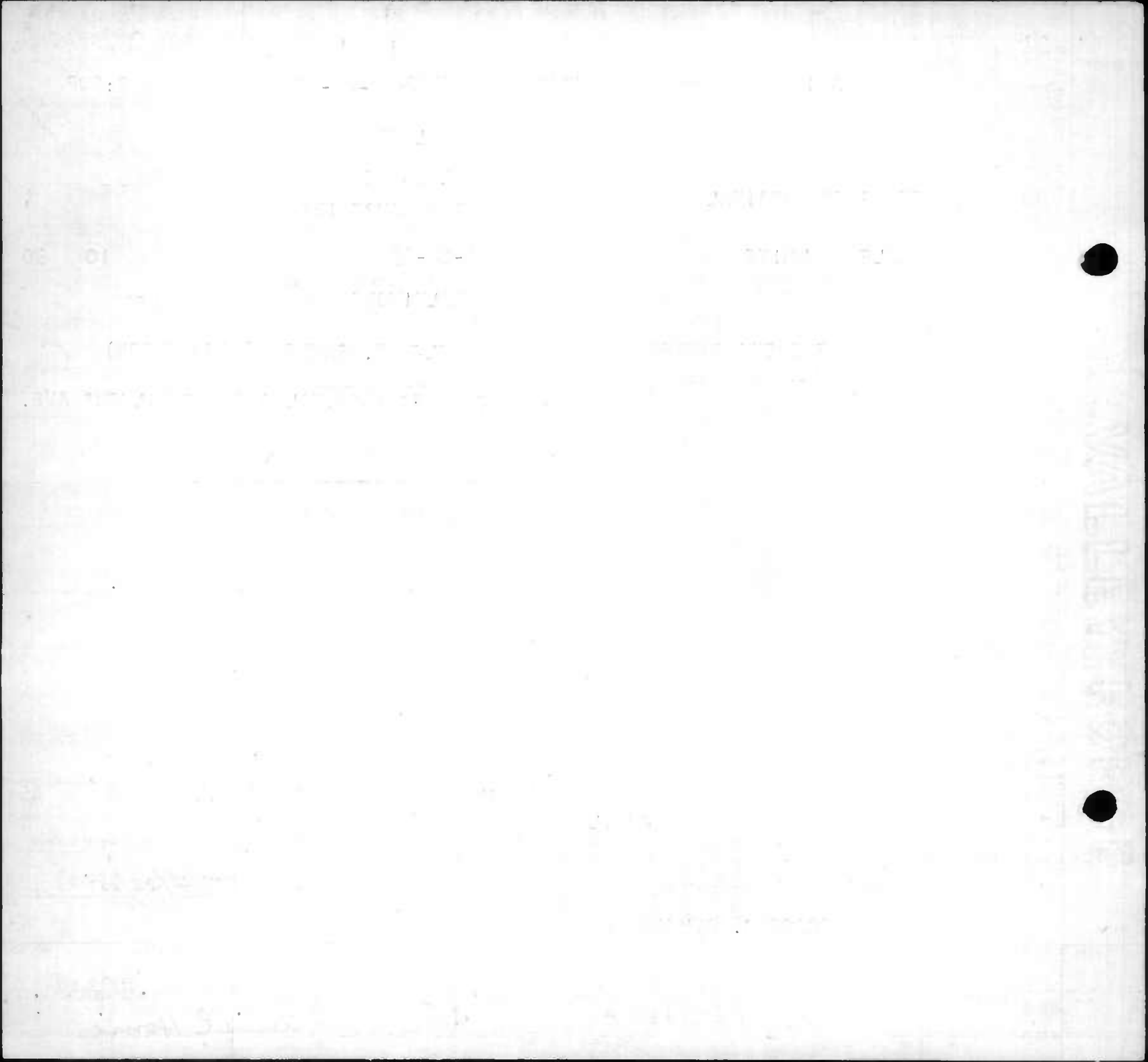
BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 4705	
CERTIFICATE OF DEATH					
BIRTH NO. 65 4705		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ALVERNA LANCASTER</b>		2. DATE AND HOUR OF DEATH <b>April 30, 1965 9:40 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>DOA md Gen Hspt.</b>		A. STATE <b>MD</b> B. COUNTY <b>1301</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>			
		D. STREET ADDRESS (If rural, give location) <b>2510 Brookfield Ave</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>1914-Feb.</b>	9. AGE (In years last birthday) <b>51</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESCLERK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>5410 STORE</b>		11. BIRTHPLACE (State or foreign country) <b>PA.</b>	
13. FATHER'S NAME <b>UNR</b>		14. MOTHER'S MAIDEN NAME <b>UNK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-24-5867</b>		17. INFORMANT <b>Roderick LANCASTER</b> ADDRESS <b>7245 STRATTONWAY</b>	
18. <b>241X I</b>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) <b>Acute heart failure</b> <b>several</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) <b>chronic bronchial asthma</b> <b>years</b>			
ANTECEDENT CAUSES		(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/28/65</b> <b>1965</b> to <b>4/30/1965</b> , that (I) (we) lost saw the deceased alive on <b>4/30/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Weinberger</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard Weinberger</b>		23D. ADDRESS <b>912 Brooks Lane - 21217</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>may 1/1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAKLAWN</b>	
24D. LOCATION (City, town, or county) (State) <b>EASTERN AVE BALTO MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 3 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Zennaro</b> ADDRESS <b>263 S. CONKLING</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4706				
BIRTH NO. 65 12084		65 4706							
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) DAVID SNYDER BABX					4-28-65 3:50P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE MARYLAND				
ST AGNES HOSPITAL					B. COUNTY BALT				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					BALTIMORE				
					D. STREET ADDRESS (If rural, give location)				
					119 HAMPSHIRE ROAD				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
MALE	WHITE		4-28-65		Infant	BALTIMORE	USA	EVERETT SNYDER	HELEN F. SNYDER (RICHARDSON)
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
no			none		ST AGNES HOSPITAL CATON & WILKENS AVE.				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					Pre maturity				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Congenital Atherosclerosis				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from APRIL 28 19 65 to APRIL 28 19 65 that (I) (we) last saw the deceased alive on APRIL 28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Grace P. Ayuyao					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4/28/65	
23C. PHYSICIAN'S NAME (Type) GRACE P. AYUYAO					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		4/30/65		New Cathedral Cemetery		Old Frederick Rd Baltora Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
MAY 4 1965		Robert E. Taylor		Grace Funeral Home 3216 S. Charles St					



1  
V-230

65 4707

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4707

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **HARRY W. VOIGT**

2. DATE AND HOUR PRONOUNCED DEAD **April 30, 1965** **2:25 p.m.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **St. Agnes Hospital**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE **Maryland**

B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **116 S. Gilmore St.**

5. SEX **male**

6. RACE **white**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Separated**

8. DATE OF BIRTH **1/12-1910**

9. AGE (In years lost birthday) **55**

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Mins.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Truck Driver**

10B. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_

11. BIRTHPLACE (State or foreign country) **Md.**

12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Henry P. Voigt**

14. MOTHER'S MAIDEN NAME **Catherine Velton**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **no**

16. SOCIAL SECURITY NO. **215-09-2148**

17. INFORMANT **Marie McDonald** ADDRESS **846 W. 37th. St.**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic and hypertensive cardiovascular disease**

(A) DUE TO \_\_\_\_\_

ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.) \_\_\_\_\_

(B) DUE TO \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. \_\_\_\_\_

(C) \_\_\_\_\_

19A. DATE OF OPERATION **3**

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_

20A. AUTOPSY? (Yes or No) **Yes**

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ UNDERLYING ☐ CONTRIBUTING

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) \_\_\_\_\_

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breiteneker** M.D.

EXAMINER'S NAME (Type) **Rudiger Breiteneker**

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **5-1-65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial**

23B. DATE **5/4, 1965**

23C. NAME OF CEMETERY or CREMATORY **London Park**

23D. LOCATION (City, town, or county) (State) **Baltimore Md.**

24A. DATE REC'D BY HEALTH DEPT. **MAY 4 1965**

24B. NAME OF REGISTRAR **Robert E. Farley, M.D.**

24C. FUNERAL DIRECTOR **Frank Heitz** ADDRESS **814 W 36th St**

VALLEY FORGE

43-40-41 AM

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 4708

BIRTH NO.

65 4708

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Rodney William Hines

2. DATE AND HOUR OF DEATH

4-29-65

7:00 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland Cecil County

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Georgetown

D. STREET ADDRESS (If rural, give location)

Post-Office Box #2

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

4-10-1937

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Mason

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Rodney W. Hines, Sr.

14. MOTHER'S MAIDEN NAME

Mary E. Gassway

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-32-2108

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

CAUSE OF DEATH

(A) Myocardial Infarction  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

1 Day

(B) Cardio Myopathy of Unknown Etiology  
DUE TO 1 Year

(C)

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-22-19 65 to 4-29-19 65,  
that (I) (we) last saw the deceased alive on 4-29 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-29-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Charles Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

May, 3, 1965

24C. NAME OF CEMETERY OR CREMATORY

Cecilton Col. Cemetery

24D. LOCATION

Cecilton, Cecil Co;

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

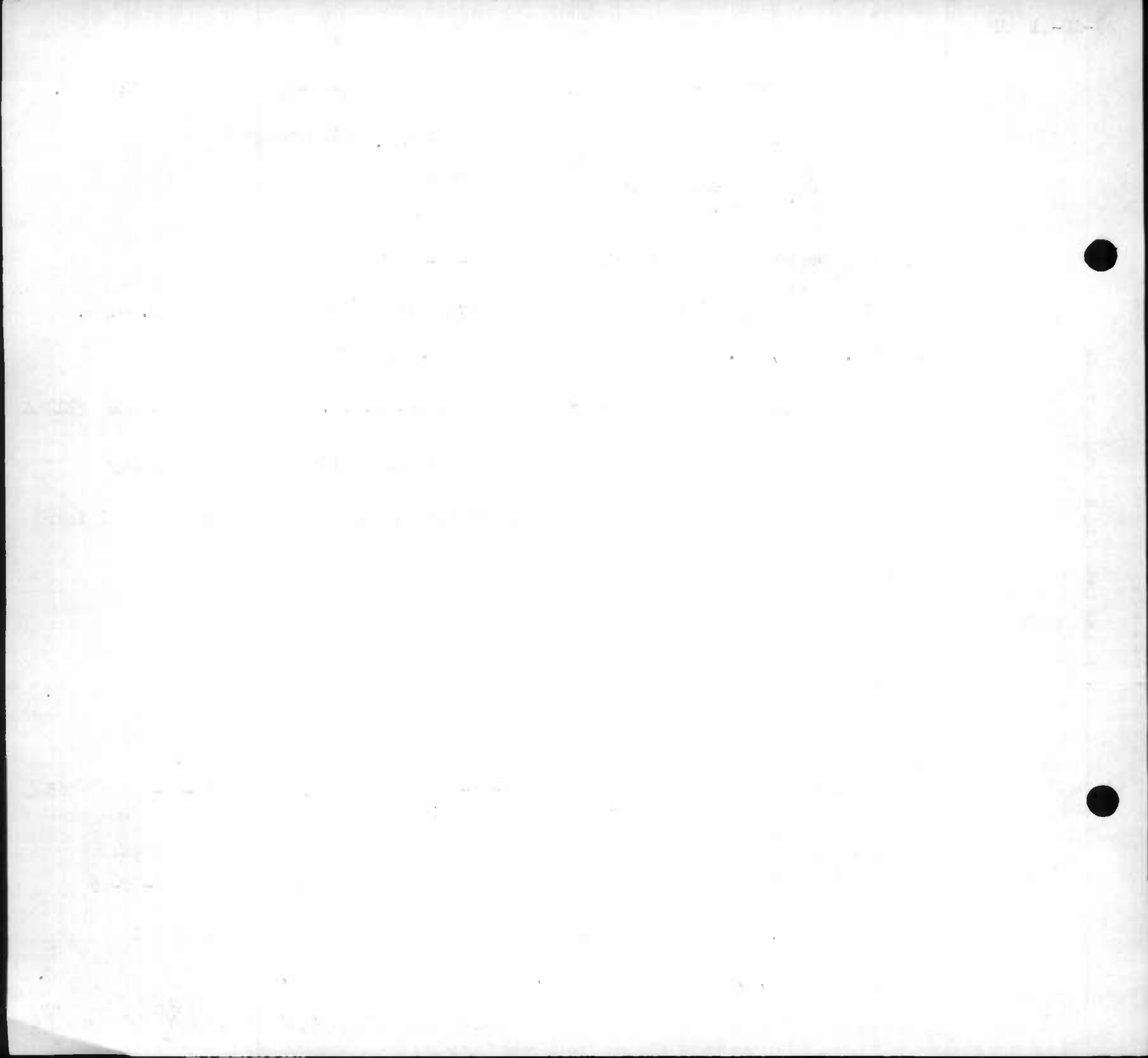
Edward H. Bellows, M.D.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

19650004706





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4709				
BIRTH NO. 65 4709					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>Anna Gaffney (Anna E. Gaffney)</b>					2. DATE AND HOUR OF DEATH <b>May 3, 1965 12:20 p.m.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinar Hospital of Baltimore</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Pikesville</b> D. STREET ADDRESS (If rural, give location) <b># 7 Randall Ave.</b>				
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>Sept. 22, 1881</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Adam Doetzer</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Wagner</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hosp. Rec.</b>				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>433.31</b> <b>Aspiration pneumonia with hypotension</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>cerebrovascular accident</b> <b>12 hours</b>				
					(C) <b>peripheral vascular disease</b> <b>??</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>4-28</b> 19 <b>65</b> to <b>5-3</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12:20 p.m. May 3, 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>Harry M. Charlutz</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>May 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Harry M. Charlutz</b>					23D. ADDRESS <b>Sinar Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>5/5/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>E. Vernon Zimmerman</b>			ADDRESS <b>4611 Park Heights Ave.</b>

John G. ...

John G. ...

John G. ...

John G. ...

John G. ...

John G. ...

John G. ...

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John G. ...

John G. ...

John G. ...

John G. ...

John G. ...

John G. ...

BIRTH NO.

65 4710

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4710

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)J.  
WILLIAM LeCOMPTÉ

2. DATE AND HOUR PRONOUNCED DEAD

5-3-65 8:58 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3351 W. Belvedere Avenue 21215

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 2, 1905

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William J. LeCompté

14. MOTHER'S MAIDEN NAME

Mary Frances Aro.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-03-1665

17. INFORMANT

ADDRESS

Mrs. Hilda LeCompté, 3351 W. Belvedere Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRI-  
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/65

23C. NAME OF CEMETERY or CREMATORY

St. Mary's Hampden

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 4 1965

Robert E. Farber, M.D.

Vernon L. Leman

4611 Park Heights Ave.

19650004718

WALLACE  
POLICE

FOR CONTACT

22

100-1-100

100-1-100

100-1-100

WILLIAM J. WALLACE

100

100

100-1-100

100-1-100

100-1-100

100-1-100

100-1-100

100-1-100

Released in Accordance with the provisions of the  
 FUNERAL DIRECTOR: IMPORTANT  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4711				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4711	
1. NAME OF DECEASED (Type or Print) <b>CHARLES F ANDERSON</b>				2. DATE AND HOUR OF DEATH <b>4-28-65 4:15 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 17, MD</b> D. STREET ADDRESS (If rural, give location) <b>2503 BARCLAY ST.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>8-2-13</b>		9. AGE (In years last birthday) <b>51</b>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELEVATOR REPAIRMAN</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALONZO ANDERSON</b>				14. MOTHER'S MAIDEN NAME <b>LILLIE MILES</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>218-05-1220</b>				16. SOCIAL SECURITY NO. <b>4220</b>		17. INFORMANT <b>PATIENT.</b>			
18. <b>410X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>RHEUMATIC HEART DISEASE &amp; MITRAL STENOSIS &amp; INSUFFICIENCY &amp; AORTIC STENOSIS CALCIFIC</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Known 4 yrs.</b>				CAUSE OF DEATH <b>RHEUMATIC HEART DISEASE &amp; MITRAL STENOSIS &amp; INSUFFICIENCY &amp; AORTIC STENOSIS CALCIFIC</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4-28-65</b>	
19A. DATE OF OPERATION <b>1 4-28-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>MITRAL STENOSIS</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>3-2 1965</b> to <b>4-28 1965</b> , that (H) (we) last saw the deceased alive on <b>4-28 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>N. W. Todd Jr.</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-28-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>NEVIN W. TODD JR.</b>				23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>6-1-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>DRUID RIDGE</b>		24D. LOCATION (City, town, or county) (State) <b>PIKESVILLE BALTO 7nd</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Frank J. Smith 814 W 36th St.</b>					

19650004719

10/15/1915

10/15/1915

10/15/1915

10/15/1915

10/15/1915

10/15/1915

10/15/1915

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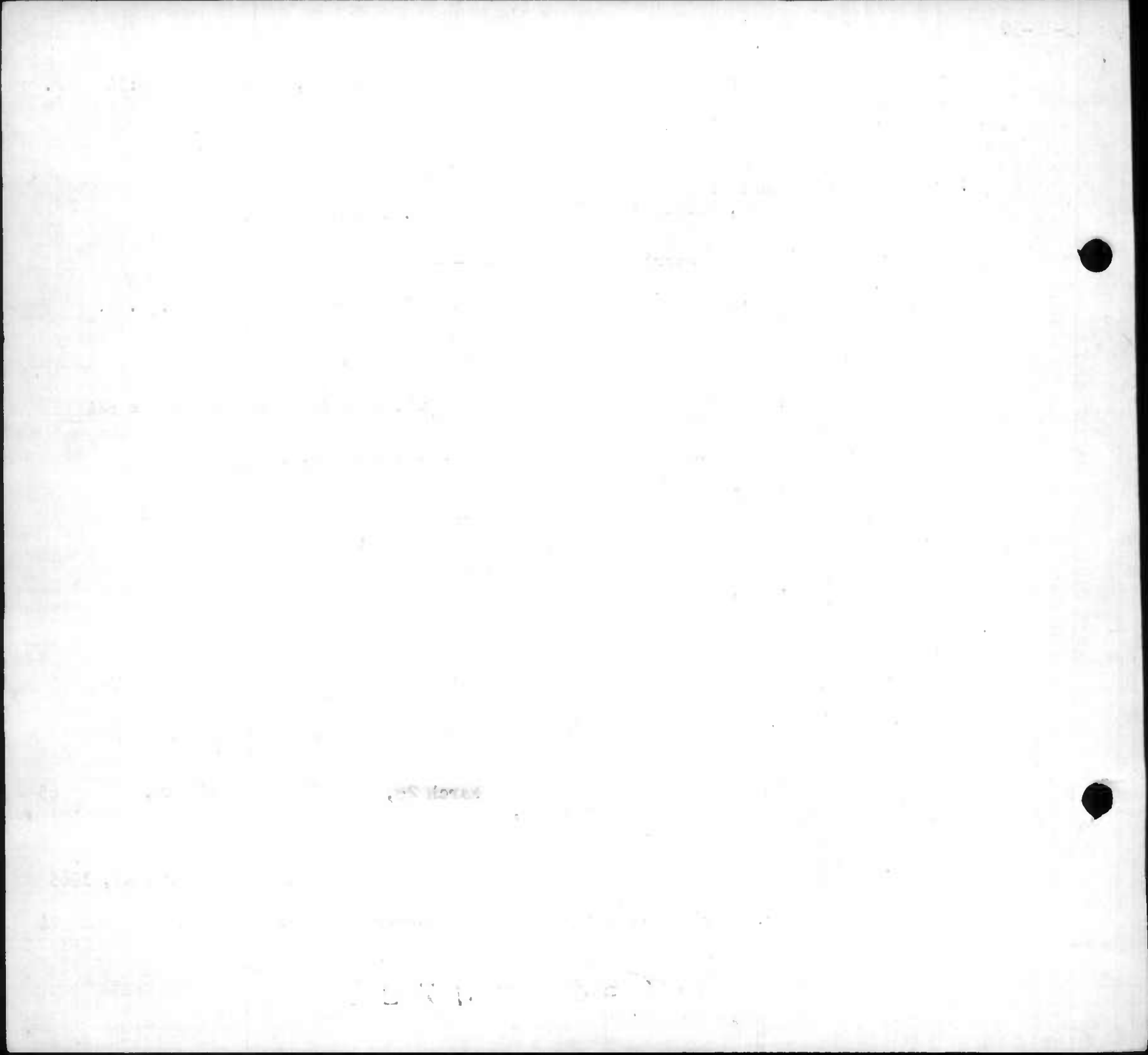
10/15/1915

IS: 43-18-30

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4712	
CERTIFICATE OF DEATH											
BIRTH NO. 65 4712		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Ralph Howard</b>				2. DATE AND HOUR OF DEATH <b>April 29, 1965</b> <b>5:30</b> P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hosptials 4940 Eastern Avenue Baltimore, Maryland #21224</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>3-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1522 E. Lombard Street 21231</b>					
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>2-5-06</b>		9. AGE (In years last birthday) <b>59</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Howard</b>						14. MOTHER'S MAIDEN NAME <b>Rose J. J. J.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>					
18. CAUSE OF DEATH <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Terminal Bronchopneumonia</b> (A) DUE TO  ANTECEDENT CAUSES (B) DUE TO <b>Right Cerebral Vascular Accident</b> (C) DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 26, 1965</b> to <b>April 29, 1965</b> , that (I) (we) lost saw the deceased alive on <b>April 29, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Charles Carpenter</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>								23B. DATE SIGNED <b>April 29, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Charles Carpenter</b>						23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>5-19-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Not Olives Cem</b>				24D. LOCATION (City, town, or county) (State) <b>North Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Washington Funeral Home</b>			





BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

TERESSA JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

4/30/65 8:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1314 Chester St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

1

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Baby

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

Bronchopneumonia

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Mongolism

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/1965

23C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

23D. LOCATION

(City, town, or county)

1 State

Brooklyn, Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 4 1965

WALLLEY FORGE

WALLLEY FORGE

WALLLEY FORGE

WALLLEY FORGE

WALLLEY FORGE

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4714					REGISTERED NO. 65 4714				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) ROBERT JOHNSON					2. DATE AND HOUR OF DEATH 4-30-65 4:30PM M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3328 GATON AVENUE				
5. SEX MALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2-28-15	9. AGE (In years last birthday) 50	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIE JOHNSON					14. MOTHER'S MAIDEN NAME AMELIA LEE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 156.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Metastatic Cancer to the Liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4-19-65 19 to 19, that (I) (we) last saw the deceased alive on 4-30-65 at 7:15 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Steve L. Johnson					23B. DATE SIGNED 4-30-65			23C. PHYSICIAN'S NAME (Type) Steve L. Johnson	
23D. ADDRESS Johns Hopkins Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/65		24C. NAME of CEMETERY or CREMATORY Arboretum Cemetery		24D. LOCATION (City, town, or county) (State) Arboretum Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR R. E. Farley			25C. FUNERAL DIRECTOR Chroy O. Williams			ADDRESS 1000 Broadway Ave	

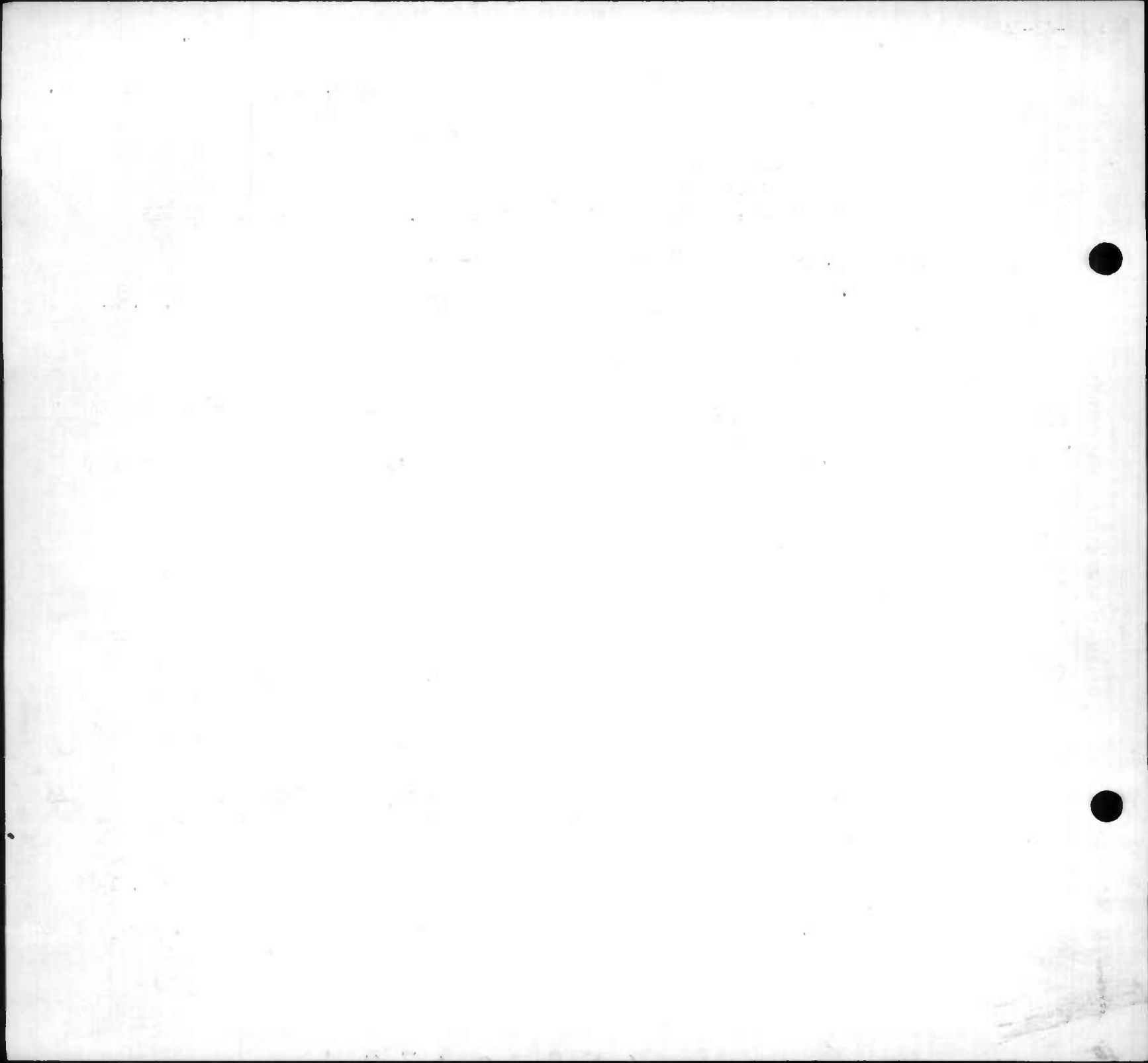
Respectfully Submitted, the Author

LS: 43-43-24 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

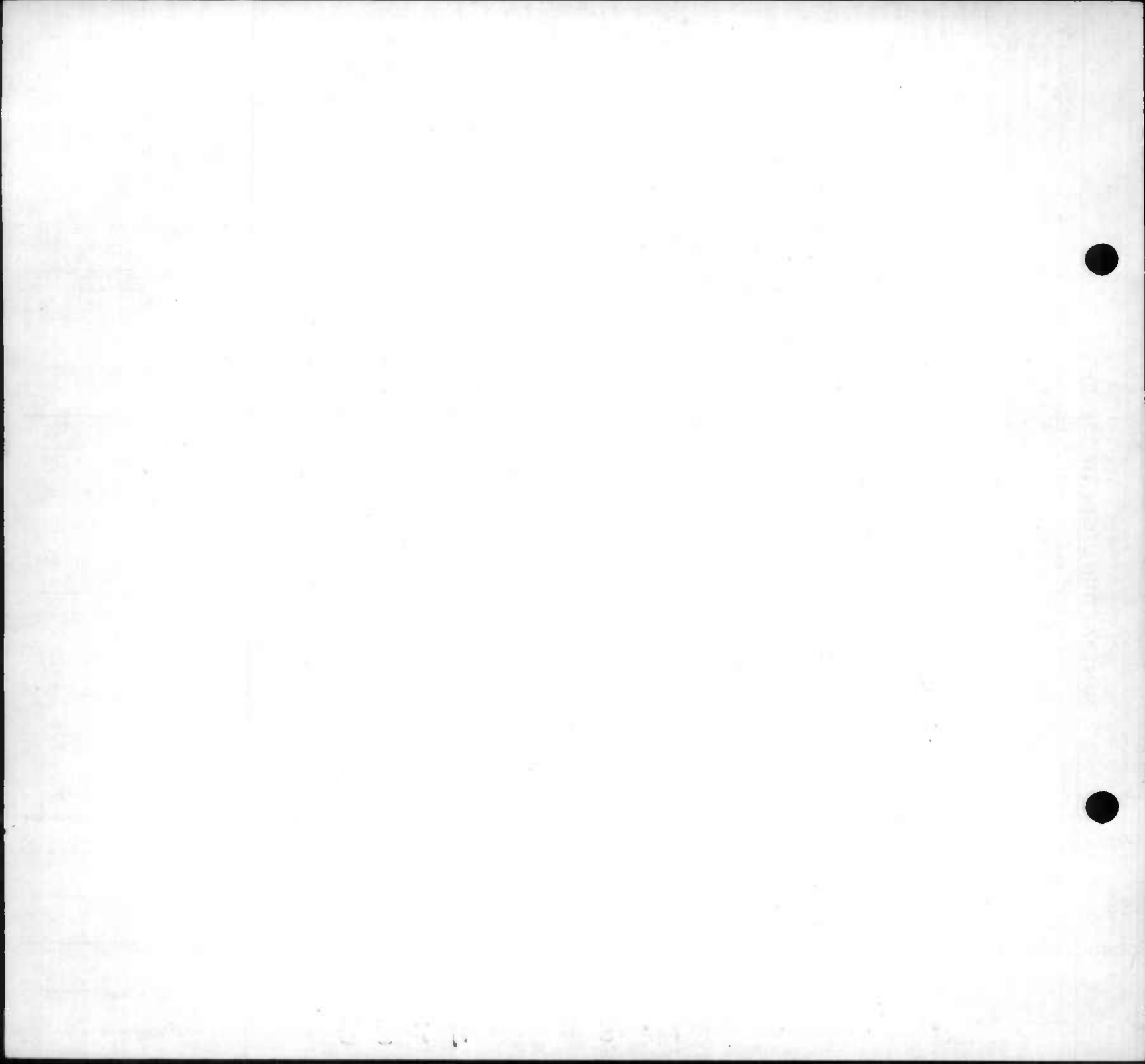
BALTIMORE CITY HEALTH DEPARTMENT														
65 4715 CERTIFICATE OF DEATH					Registered No. 65 4715									
BIRTH NO.					M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
Edith Claiborne					May 2, 1965 7:15 A. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE									
Baltimore City Hosptials 4940 Eastern Avenue Baltimore, Maryland #21224					Maryland									
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
					Baltimore									
					D. STREET ADDRESS (If rural, give location)									
					1837 N. Register Street #21213									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)						
Female		Negro		Married		4-15-10		55						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?								
				Maryland		U. S. A.								
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No.							RECORDS: BCH: 4940 Eastern Avenue #24							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
274X I					Addison's Disease					? 1 Month				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO									
					(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Pelvic Mass					3 Years				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
2										Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from April 25, 19 65 to May 2, 19 65, that (I) (we) last saw the deceased alive on May 2, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED				
Dr. Howard Rathbun										May 2, 1965				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS									
Dr. Howard Rathbun					M.D. 4940 Eastern Avenue Baltimore, Maryland #24									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY				
Burial					5/6/1965					Arlington Cemetery				
24D. LOCATION (City, town, or county) (State)														
Baltimore Md														
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR ADDRESS				
MAY 4 1965					Robert E. Farley M.D.					Elroy C. Wilson 1000 Brantly Ave				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4716</b>	
BIRTH NO. <b>65 4716</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Burley, Lorraine Elizabeth</b>			
2. DATE AND HOUR OF DEATH <b>29 April 1965 1:50 A.M.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>4-02</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>221 N. Fremont Ave</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Separated</b>	8. DATE OF BIRTH <b>11/1/28</b>	9. AGE (In years last birthday) <b>36</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Walter Carroll</b>		14. MOTHER'S MAIDEN NAME <b>Gladys American</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Gladys Carroll</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>743-X I</b>		CAUSE OF DEATH (A) DUE TO <b>Hyperkalemia &amp; Azotemia</b> (B) DUE TO <b>Renal Failure</b> (C) DUE TO <b>Malignant hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>-</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <b>-</b>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (this hospital) attended the deceased from <b>29 March 1965</b> to <b>29 April 1965</b> , that (we) last saw the deceased alive on <b>29 April 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward J. Ruley, MD</b>				23B. DATE SIGNED <b>29 April 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Edward J. Ruley</b>				23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. Auburn Cem.</b>	
24D. LOCATION <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>S. G. Walcott 1000 Brantley Ave.</b>			

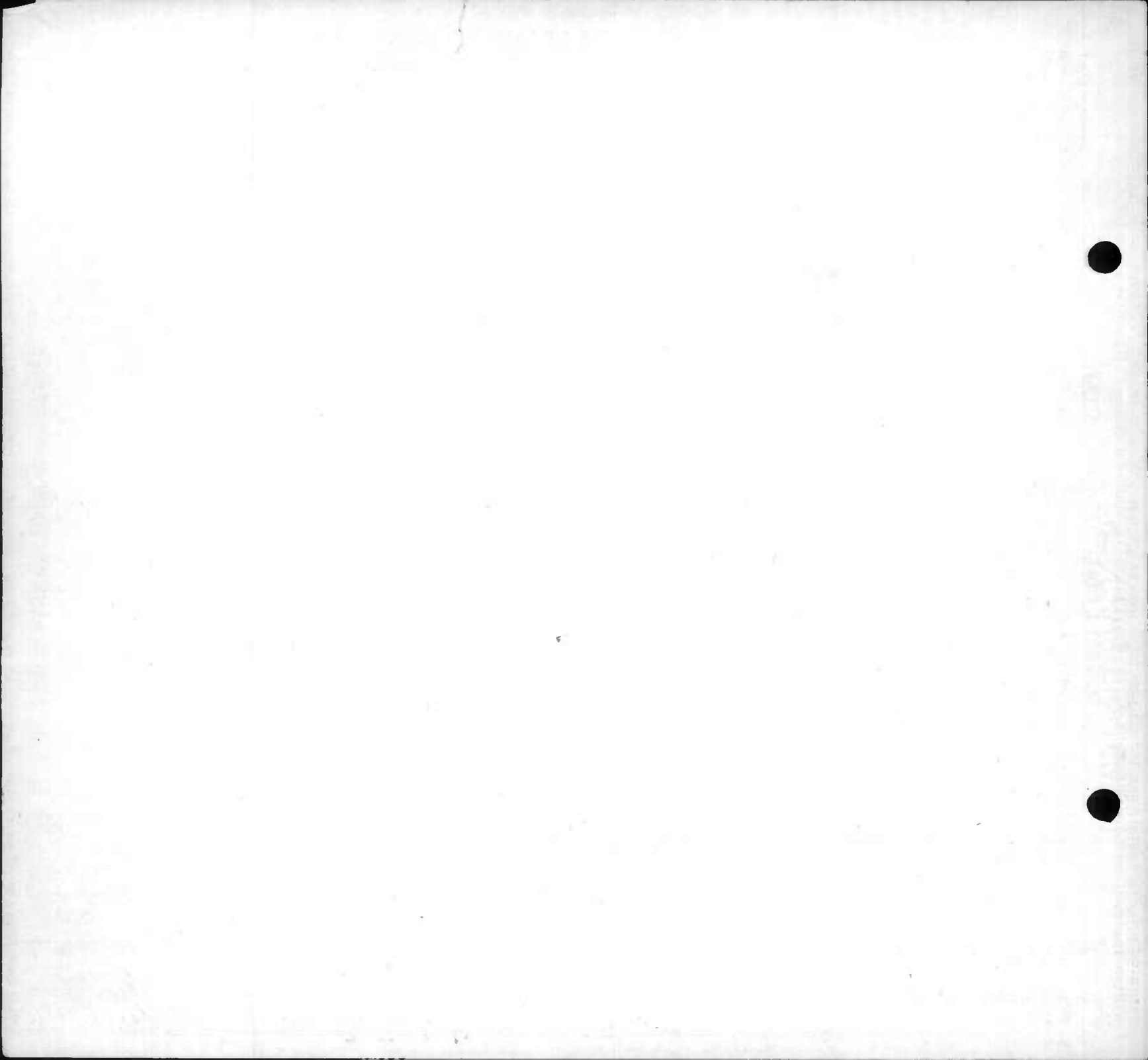




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4717	
BIRTH NO.				65 4717	
M.E. CASE NO.				65 4717	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ALGERNON M.A. JACKSON SR.			MAY 1 - 1965 5:00 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE MD		
1615 EDMONDSON AVE.			B. COUNTY BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			D. STREET ADDRESS (If rural, give location)		
			1615 EDMONDSON AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M.	Colored	MARRIED	12-27-1887	77	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
MINISTER			BALTO MD		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
RANDALL JACKSON			VIOLET		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
NO			216-28-2289		
17. INFORMANT			ADDRESS		
ESTHER JACKSON			1615 EDMONDSON AVE		
18. 420.1 I			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.)			Coronary Occlusion Day		
ANTECEDENT CAUSES			Central Hemorrhage Several wks		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			Cardio Vascular Disease Unknown		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work			
22. I certify that (I) (this hospital) attended the deceased from 5-1-1965 to 5-1-1965, that (I) (we) last saw the deceased alive on 4-30-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard H. Hunt				5/3/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard H. Hunt				160 W. Mulberry St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/4/65		Mt Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 4 1965		Robert E. Fairbank		Hunt & Sons 638 N. 9th St	

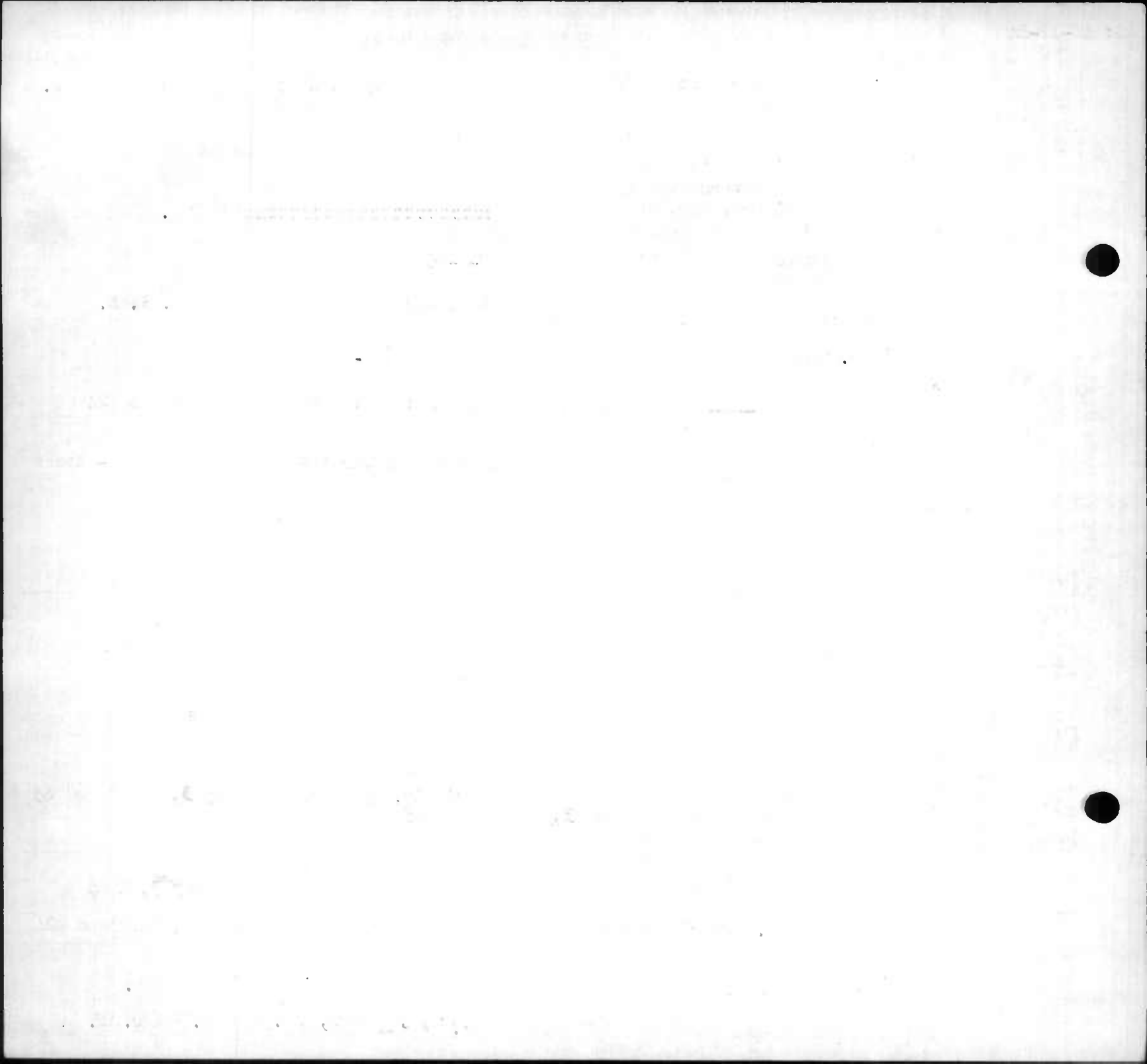


LS: 40-17-14

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		65 4718		CITY HEALTH DEPARTMENT		REGISTERED NO.		65 4718	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Margaret Paff</b>					
2. DATE AND HOUR OF DEATH <b>May 3, 1965</b>				7:00 A. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>					
				D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Avenue #24 602 E. 47th St</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>7-4-86</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
13. FATHER'S NAME <b>Louis V. Paff</b>				14. MOTHER'S MAIDEN NAME <b>Margaret A. Shannery</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardio-Vascular Disease - Years</b>				INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1964</b> to <b>May 3, 1965</b> . that (I) (we) last saw the deceased alive on <b>May 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Dr. Howard Rathbun</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 3, 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Howard Rathbun</b>				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>John A. Morgan, Inc.</b>		ADDRESS <b>3000 E. Balto. St.</b>			



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

GEORGE DUKES

2. DATE AND HOUR PRONOUNCED DEAD

5-3-65

12:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

12 N. Milton Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Oct. 27, 1898

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

Painting

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frederick Duke

14. MOTHER'S MAIDEN NAME

Bertha Schmeizer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

217-32-9266

17. INFORMANT

Edward J. Duke

ADDRESS

227 N. Lakewood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/65

23C. NAME OF CEMETERY or CREMATORY

Trinity Lutheran Cem.

23D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

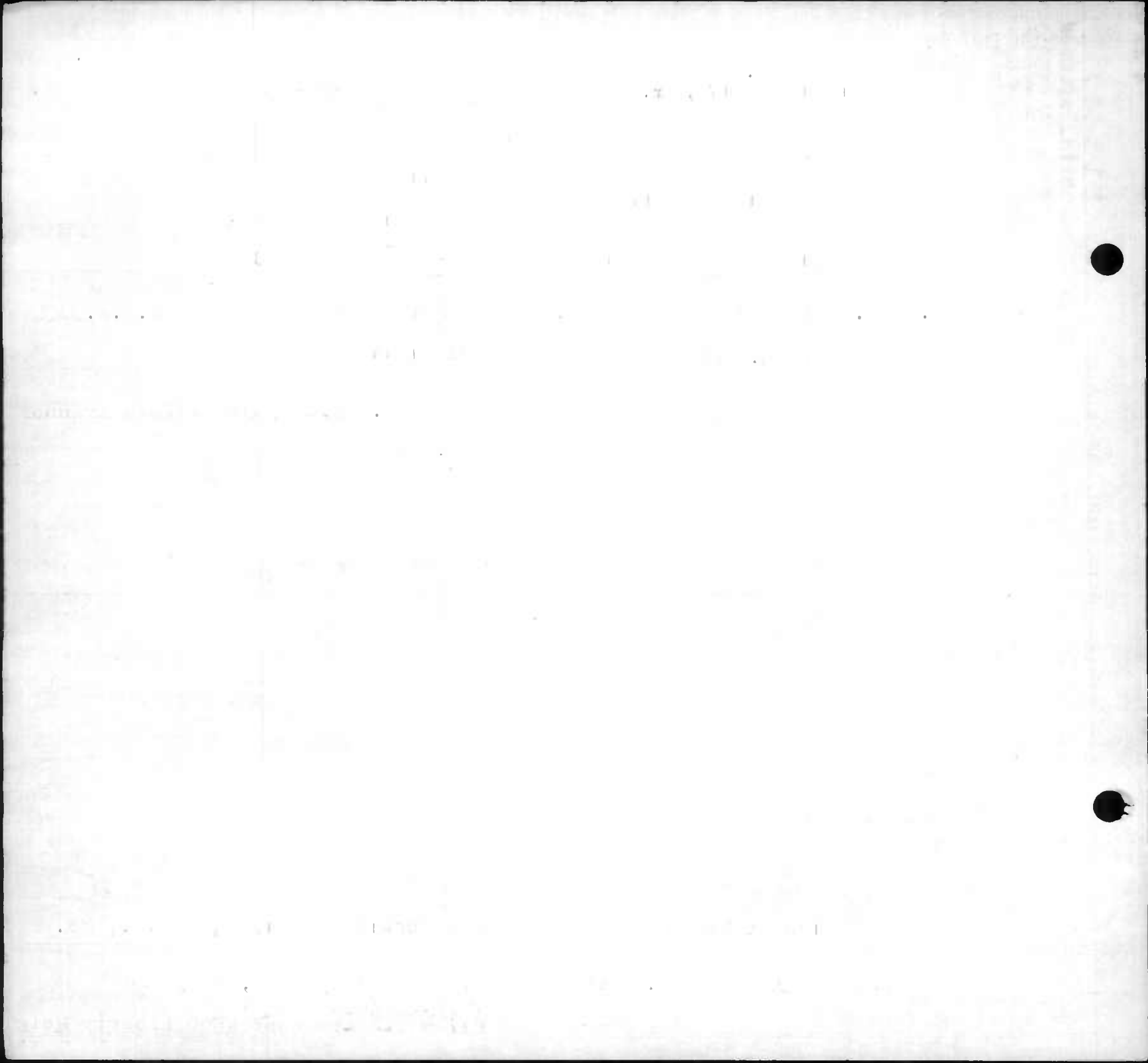
ADDRESS

VALLEY FORGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4720					REGISTERED NO. 65 4720				
M.E. CASE NO.					BALTIMORE CITY HEALTH DEPARTMENT				
1. NAME OF DECEASED (Type or Print) R. WILLIAM SMITH, Sr.					2. DATE AND HOUR OF DEATH 4-29-65 6:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7				
					D. STREET ADDRESS (If rural, give location) 3616 MILFORD AVENUE				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 82 8-29-88	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B. & O. Railroad			10B. KIND OF BUSINESS OR INDUSTRY Relief Department		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH B. Smith					14. MOTHER'S MAIDEN NAME HENRIETTA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Augustus V. Smith 3616 Milford Avenue				
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					(A) DUE TO CARDIAC ARREST ?				
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(B) DUE TO GT HEMORRHAGE ?				
ANTECEDENT CAUSES					(C) DUE TO PEPTIC ULCER DISEASE ?				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 4/27 1965 to 5/1/65, that (I) last saw the deceased alive on 4/29 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE Michael Lesch					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 9/29/65		
23C. PHYSICIAN'S NAME (Type) MICHAEL LESCH					23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL, BAL TO., MD.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/65		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. Farkley		25C. FUNERAL DIRECTOR Ellisworth Armacost		ADDRESS 4600 Liberty Heights			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4721					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4721				
1. NAME OF DECEASED (Type or Print) John Patrick Nolan, Sr.					2. DATE AND HOUR OF DEATH April 29, 1965				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3708 Sequoia Avenue					A. STATE B. COUNTY Maryland				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore				
					D. STREET ADDRESS (If rural, give location) 3708 Sequoia Avenue				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11/21/85	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.1			16. SOCIAL SECURITY NO. Yes		17. INFORMANT ADDRESS Doris Weber Nolan-3708 S quoa Avenue				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Ch. Prostate Gland Generalized Metastasis Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jan 1964 to April 23 1965, that (I) (we) last saw the deceased alive on Apr 25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Paul Byerly					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 4/30/65	
23C. PHYSICIAN'S NAME (Type) M. Paul Byerly					23D. ADDRESS 5820 York Rd Baltimore Md				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/65		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965			25B. NAME OF REGISTRAR Robert E. Fadden			25C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave			

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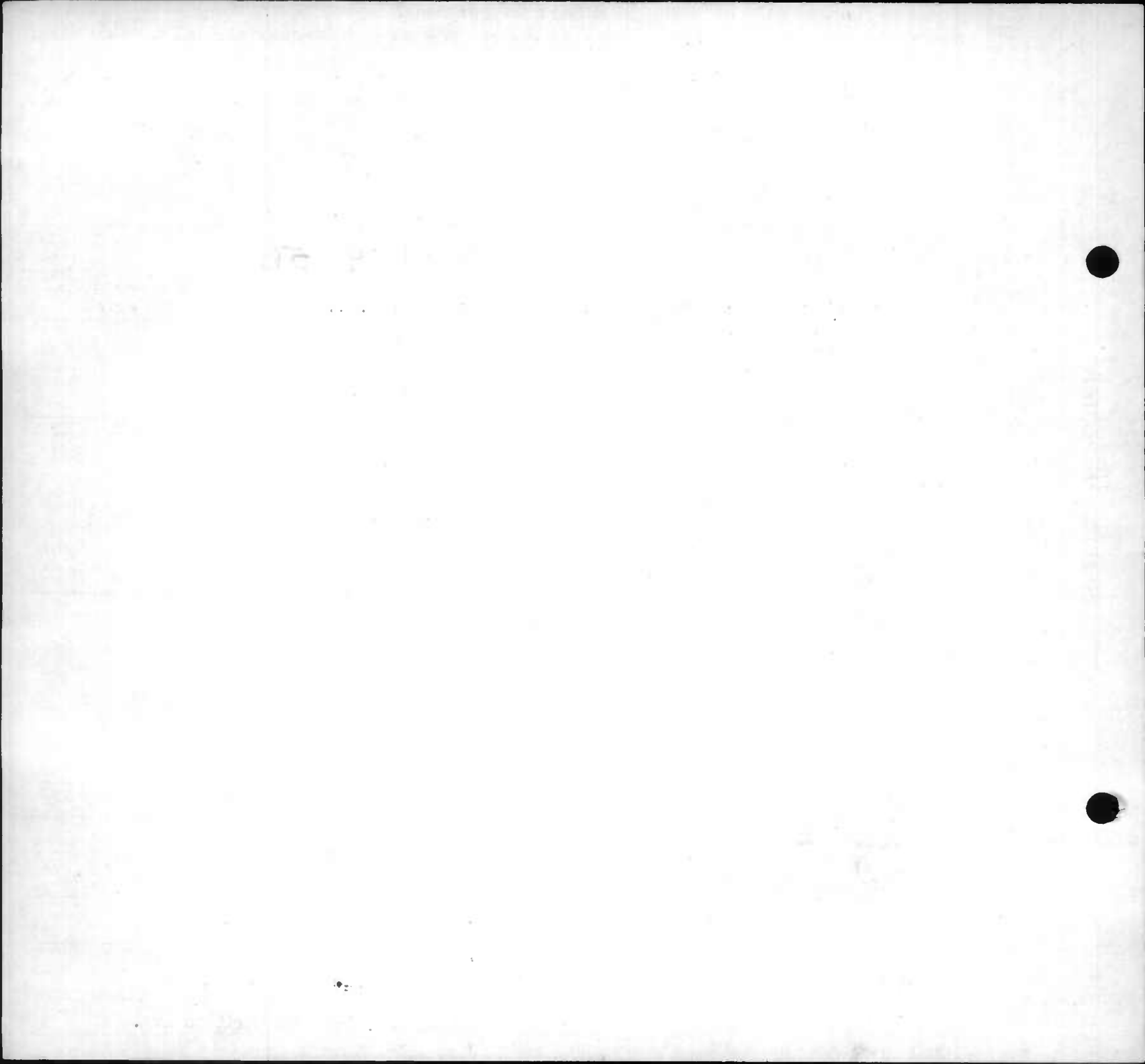
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

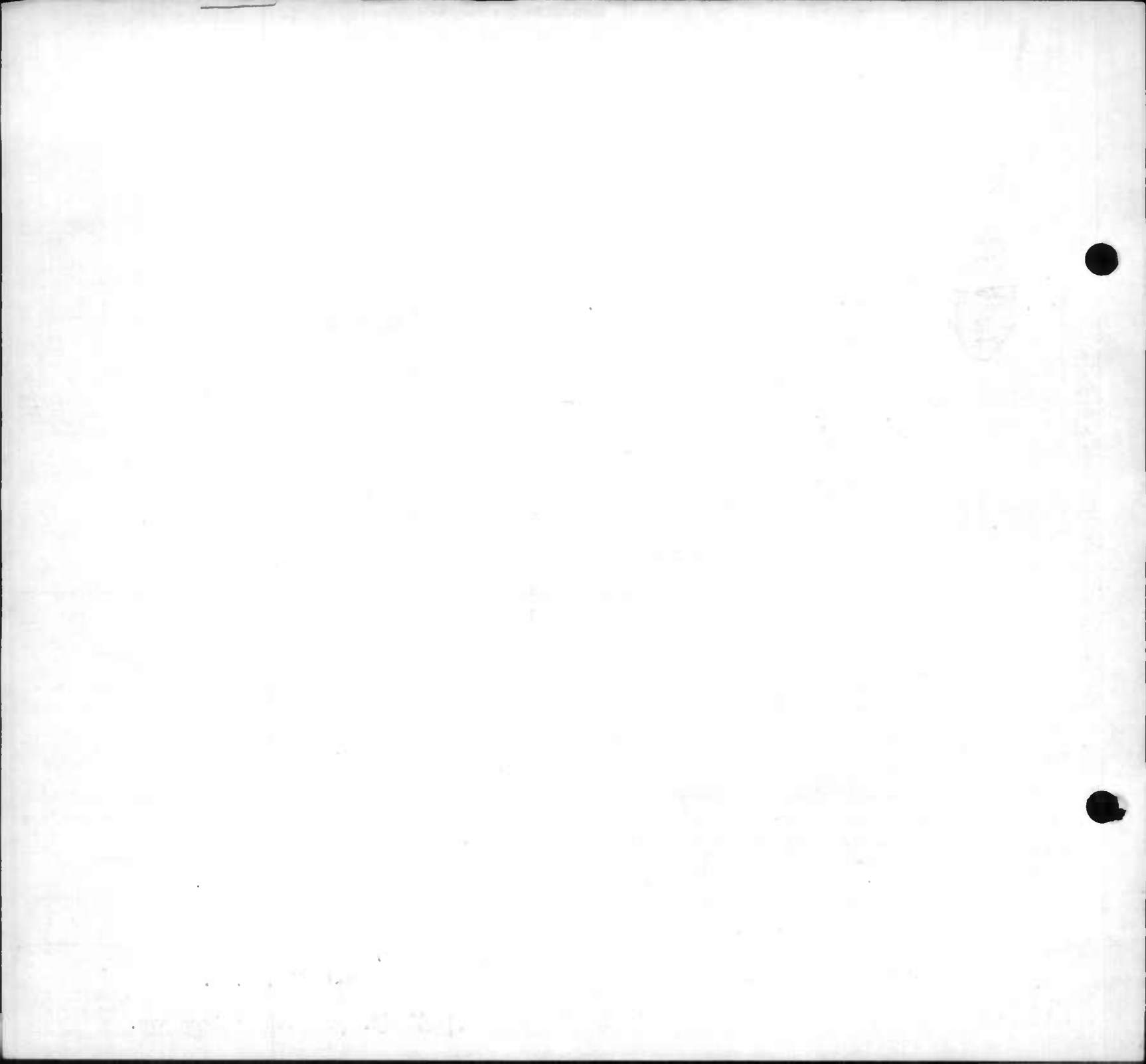
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4722</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4722</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Cleophus Boozer, Sr</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4/30/65</span> <span style="float: right;">7:10 AM</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">SINAI HOSPITAL</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CITY</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE CITY 15-03</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1500 Moreland Ave</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">N</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4/16/1909</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Upholstering</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Malpass Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Newberry, S. C.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Lud Boozer</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Lake</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Cleophus Boozer Jr.</span>		ADDRESS	
18. <span style="font-size: 1.2em;">331X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cerebral Vascular Hemorrhage</span> DUE TO (B) <span style="font-size: 1.2em;">Cerebral Vascular Malformation</span> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">3 days</span> <span style="font-size: 1.2em;">?(congenital)</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>the</del> (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/27</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">4/30</span> 19 <span style="font-size: 1.2em;">65</span> , that <del>the</del> (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/27</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Melvin J. Kordon</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4/30/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MELVIN J. KORDON</span>				23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-4-65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Arbutus Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 4 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Charles R. Law</span>		ADDRESS <span style="font-size: 1.2em;">802 Madison Ave.</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

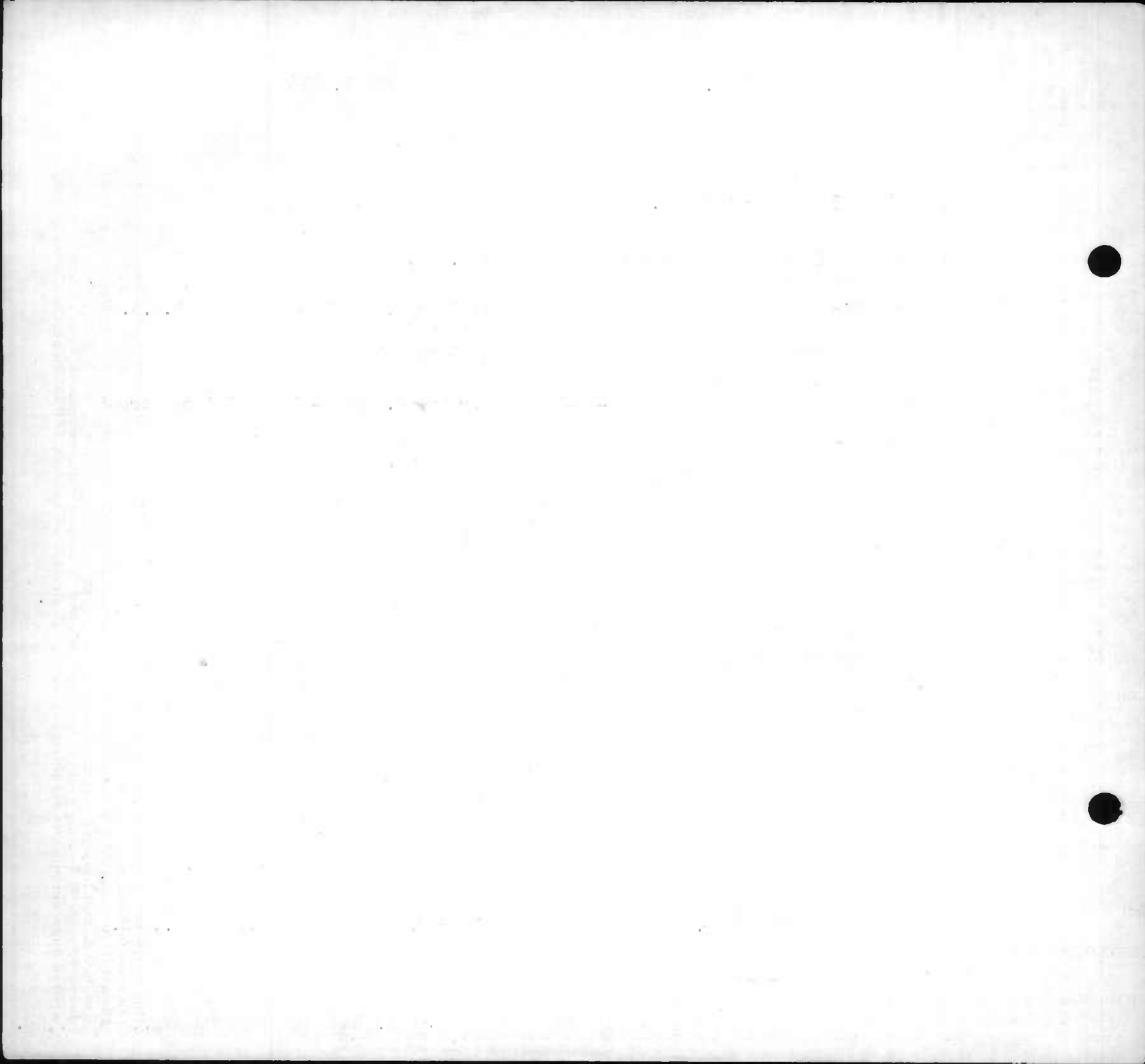
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4723</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4723</span>							
M.E. CASE NO. <span style="font-size: 1.2em;">65 4723</span>							
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Gilbert F. McGee</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5-5/1/65 6 AM</span> <span style="font-size: 1.2em;">6A</span> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">University Hospital</span>				A. STATE <span style="font-size: 1.2em;">Md.</span>			
				B. COUNTY <span style="font-size: 1.2em;">16-05</span>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>			
				D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">2327 W. Mosher St.</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Negro</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">6/28/88</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">76</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Roofing Co.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">South Carolina</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">FRANK McGee</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">—</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">250-07-8955</span>		17. INFORMANT <span style="font-size: 1.2em;">J D Lawrence, M.D. University Hospital</span>			
18. <span style="font-size: 1.2em;">593X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Coronary Sclerosis Secondary to Hypertension possible Rheumatic Heart Disease</span> (B) <span style="font-size: 1.2em;">—</span> (C) <span style="font-size: 1.2em;">—</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">—</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/21</span> <span style="font-size: 1.2em;">1965</span> to <span style="font-size: 1.2em;">5/1</span> <span style="font-size: 1.2em;">1965</span> , that (I) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">5/1</span> <span style="font-size: 1.2em;">1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">George D. Lawrence</span>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/1/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">George D. Lawrence</span>				23D. ADDRESS <span style="font-size: 1.2em;">University Hospital</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-4-65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Ebenezer Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Rock Hill, S. C.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 4 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Stacker</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Charles E. Law</span>		ADDRESS <span style="font-size: 1.2em;">802 Madison Ave.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4724		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 65 4724	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LILLIE M. KING			2. DATE AND HOUR OF DEATH MAY 1, 1965 4:30 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nursing Home 2600 Fairview Ave.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1626 Division Street		
5. SEX Female	6. RACE Colored	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 13, 1896	9. AGE (In years last birthday) 68	(If Under 1 Yr. Months: Days: Hours: Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George Bundy		
14. MOTHER'S MAIDEN NAME Lucy Voten			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 215-32-1114A			17. INFORMANT ADDRESS Arthur J. Ryan - 1626 Division Street		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 10 days		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/65 to 5/1/65, that (I) (we) last saw the deceased alive on 4/30/65 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W. Garner			23B. DATE SIGNED 5/3/65		
23C. PHYSICIAN'S NAME (Type) WILLIAM M. GARNER			23D. ADDRESS M.D. 1005 W. LAFAYETTE AVE., BALTO., MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-4-65		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 MADISON AVE., BALTO., MD.			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

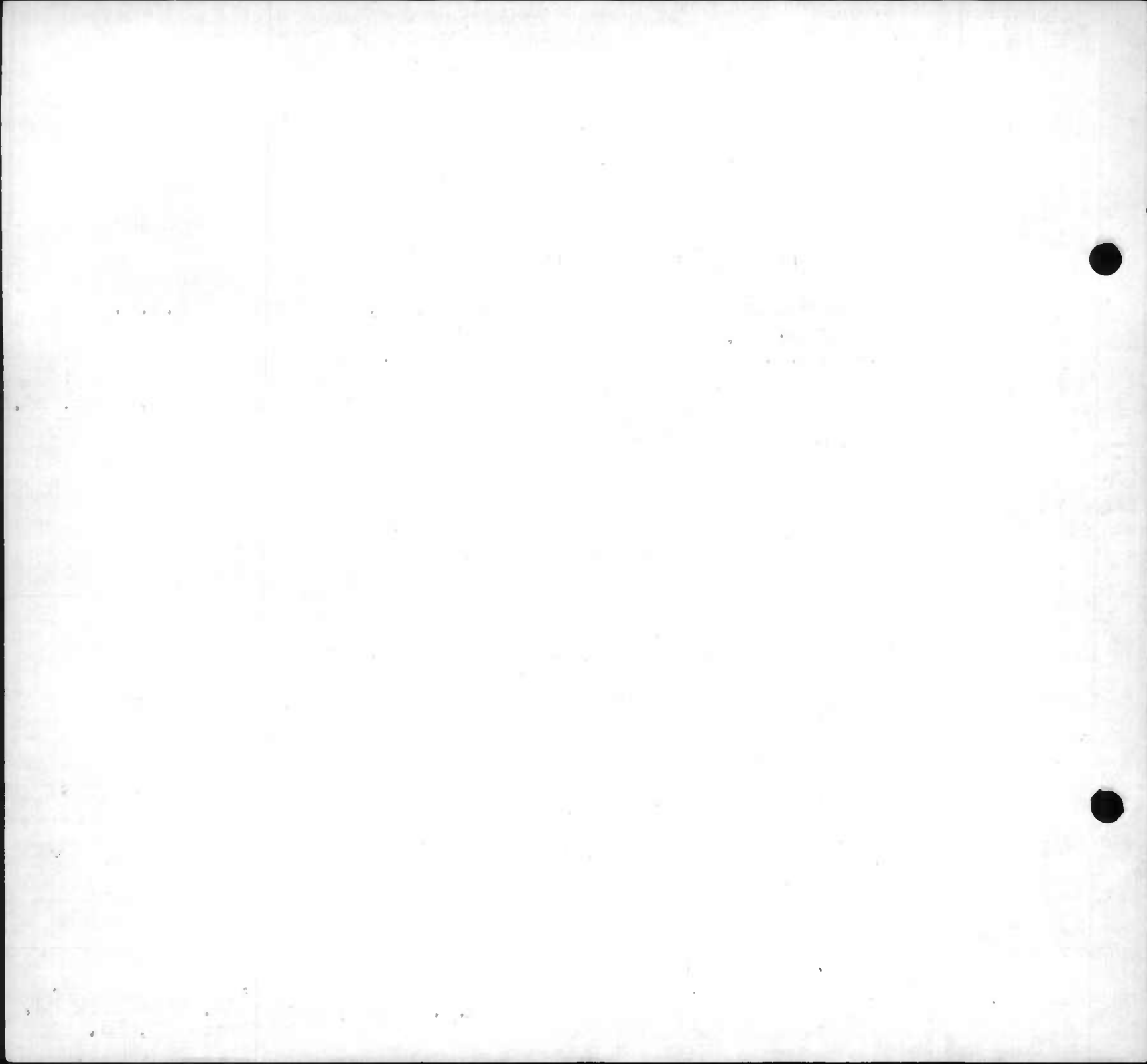
Baltimore City Health Department				Certificate of Death		Registered No. 65 4725	
BIRTH NO. 65 4725		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) WOLF APPLEBAUM		2. DATE AND HOUR OF DEATH MAY 2, 1965 10:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines, Bel.				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO 15-12			
				D. STREET ADDRESS (If rural, give location) 3904 PARK HEIGHTS AVE			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET		10B. KIND OF BUSINESS OR INDUSTRY Shoe MAKER		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-34-3177		17. INFORMANT DR. JOHN BECKER		ADDRESS 3704 LIBERTY HEIGHTS	
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) DUE TO Respiratory failure			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO Hemiplegia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C) DUE TO Hypertension & arteriosclerotic Cardiac disease, cerebral disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) N		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1959 to April 2 1965, that (I) (we) last saw the deceased alive on April 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE J. Shorofsky M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/3/65	
23C. PHYSICIAN'S NAME (Type) S BOROFFSKY				23D. ADDRESS M.D. 4734 PARK HEIGHTS AVE BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/65		24C. NAME OF CEMETERY or CREMATORY Rosedale		24D. LOCATION (City, town, or county) Balto MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc.		ADDRESS 3314 Olympia Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
65 4726					Registered No. 65 4726					
BIRTH NO.					M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) LAURENCE M. SIMMONDS					2. DATE AND HOUR OF DEATH 5/3/65 12 <sup>05</sup> P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND					
(If not in hospital or institution, give street address or location)					B. COUNTY HARFORD					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) ABINGDON					
					D. STREET ADDRESS (If rural, give location) BOX HILL					
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED		8. DATE OF BIRTH 9-14-87	9. AGE (In years lost birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investment Banker			10B. KIND OF BUSINESS OR INDUSTRY Finance		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Alfred A. SIMMONDS					14. MOTHER'S MAIDEN NAME MARY V. Bay					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Miss Gene Simmonds, Handful, Joppa, Md.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 443X I CAUSE OF DEATH (A) Respiratory arrest (B) subarachnoid hemorrhage (C) hypertension, ASCVD INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 2 hrs. 20 years										
19. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 5/2 1965 to 5/3 1965 that (I) last saw the deceased alive on 5/3 1965 and that in (my) (our) opinion death occurred on the date (and hour and from the causes stated above. (I) (we) (did) (didn't) view the body after death.										
23A. SIGNATURE Frederic B. Askin					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/3/65			
23C. PHYSICIAN'S NAME (Type) FREDERIC B. ASKIN, M.D.					23D. ADDRESS Johns Hopkins Hosp. 7th					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/1965		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965			25B. NAME OF REGISTRAR Robert E. Fairbank			25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md.			ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

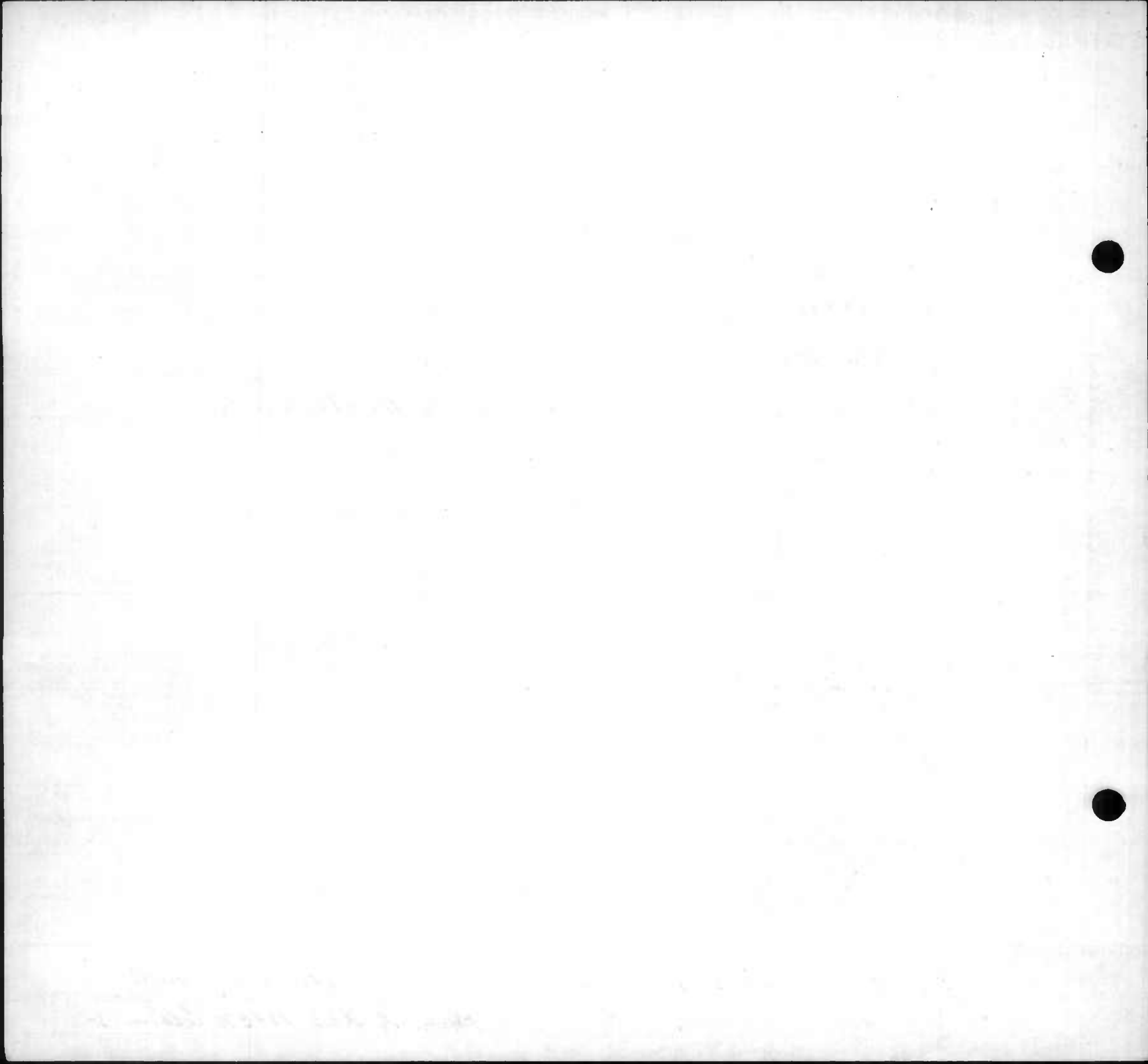
BALTIMORE CITY HEALTH DEPARTMENT				65 4727	
BIRTH NO.				65 4727	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Martha Harden			May 3, 1965 3:45p M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Provident Hospital			Maryland		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			2016 Clifton Avenue		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Female	Negro	Married	June 20, 1916	45	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
					Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Samuel Green			Alice Ennis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO			220-20-2991		Leroy Harden-husband same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Cerebral Hemorrhage		
ANTECEDENT CAUSES			DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Hypertensive Cardiovascular disease		
			DUE TO		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-3-65 19 to 5-3-65 19, that (I) (we) last saw the deceased alive on 5-3-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Hollis Seunarine, M.D.				May 3, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Hollis Seunarine				1514 Division Street Baltimore 17, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/7/65		Baltimore Natl. Cem.	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 4 1965		Robert E. Taylor		George S. Kelan 1848 N. Calhoun St	

100,000,000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4728		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4728	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Elenora VIOLA PENN (Pinn)</i>		2. DATE AND HOUR OF DEATH <i>2:00 PM 5/2/65 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTI.</i>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE, MD.</i>			
		D. STREET ADDRESS (If rural, give location) <i>2030 Madison Avenue</i>			
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>single</i>	8. DATE OF BIRTH <i>2/6/99</i>	9. AGE (In years last birthday) <i>66.</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>JOSEPH PENN</i>			14. MOTHER'S MAIDEN NAME <i>IDA LEE</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>228-32-9456</i>	17. INFORMANT ADDRESS <i>Mable Brooks 1541 Woodyear St</i>		
18. <i>5-70-21</i>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>BOWEL OBSTRUCTION.</i>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>MESENTERIC VASC INSUF.</i>		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>3 4/26</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>SMALL BOWEL OBST.</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 23</i> 19 <i>65</i> to <i>May 2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>May 2</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. Gregory Kane</i>				23B. DATE SIGNED <i>5/2/65</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-6-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn Cem.</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Stacy A. Elder 1348 N. Calhoun St</i>	

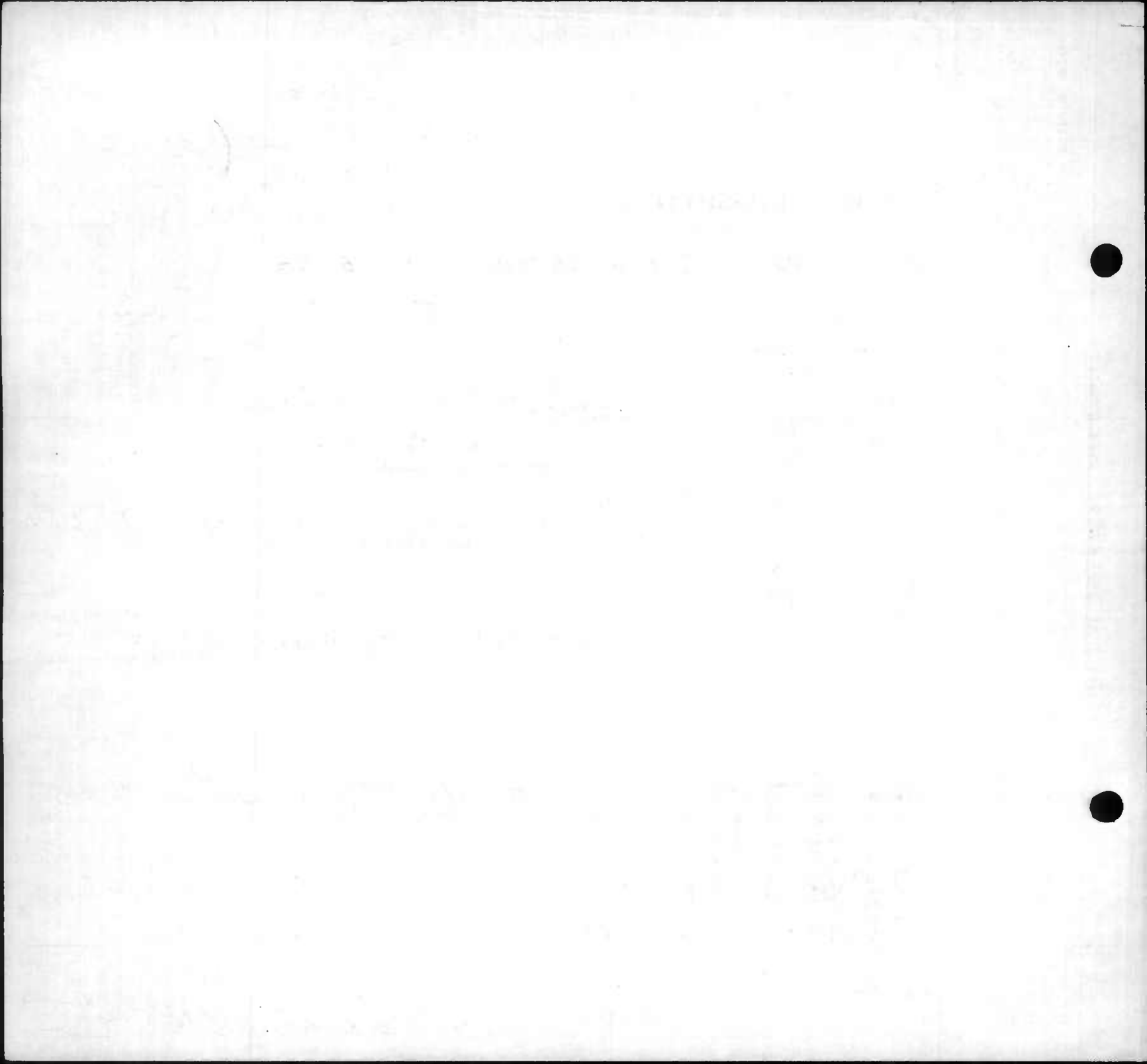




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
65 4729					CERTIFICATE OF DEATH					Registered No. 65 4729					
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					
					2. DATE AND HOUR OF DEATH										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE					B. COUNTY					
					MARYLAND					BALTIMORE CITY					
SINAI HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township)										
					BALTIMORE					13-07					
					D. STREET ADDRESS (If rural, give location)										
					3641 ELM AVE #11										
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
M		W		SINGLE (Married)		7/5/1905		58							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
				-				VA.				U.S.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
-					UNK					UNK					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
NO					21801-6467					OLD RECORD					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
					probable Myocardial Infarction					8 hrs.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO										
					(B) Arteriosclerotic Cardiovascular Disease					10 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO										
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					
0															
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?					
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										
22. I certify that (I) (this hospital) attended the deceased from 5/2/65 7 AM to 5/2/65 2 PM, that (H) (we) last saw the deceased alive on 5/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.															
23A. SIGNATURE										23B. DATE SIGNED					
Melvin J. Gordon										5/2/65					
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS										
Melvin J. Gordon					SINAI HOSPITAL										
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)							
BURIAL		5-5-65		ST. MARY'S CEMETERY		BALTO MD.									
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR ADDRESS					
MAY 4 1965					Robert E. Fisher					3641 Elm Ave #11					



LS: 43-2182 ]

#BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4730

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Wessell Tarum

2. DATE AND HOUR OF DEATH

May 1, 1965

8:35 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2821 Georgetown Road 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

5-12-05

9. AGE (In years  
last birthday)

59

If Under 1 Yr.  
Months: DaysIf Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Butcher

10B. KIND OF BUSINESS OR INDUSTRY

Md. Beef Prov. Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Louis Tarum

14. MOTHER'S MAIDEN NAME

Elizabeth Kluth

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

216-05-8123

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue Baltimore, MD

18. 193.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) \_\_\_\_\_  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) \_\_\_\_\_  
DUE TO

(C) Frontal Astrocytoma Grade III 6 Months

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 30, 19 65 to May 1, 19 65,  
that (I) (we) last saw the deceased alive on May 1, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 1, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-4-1965

24C. NAME OF CEMETERY or CREMATORY

Meadowridge Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

George J. Gance

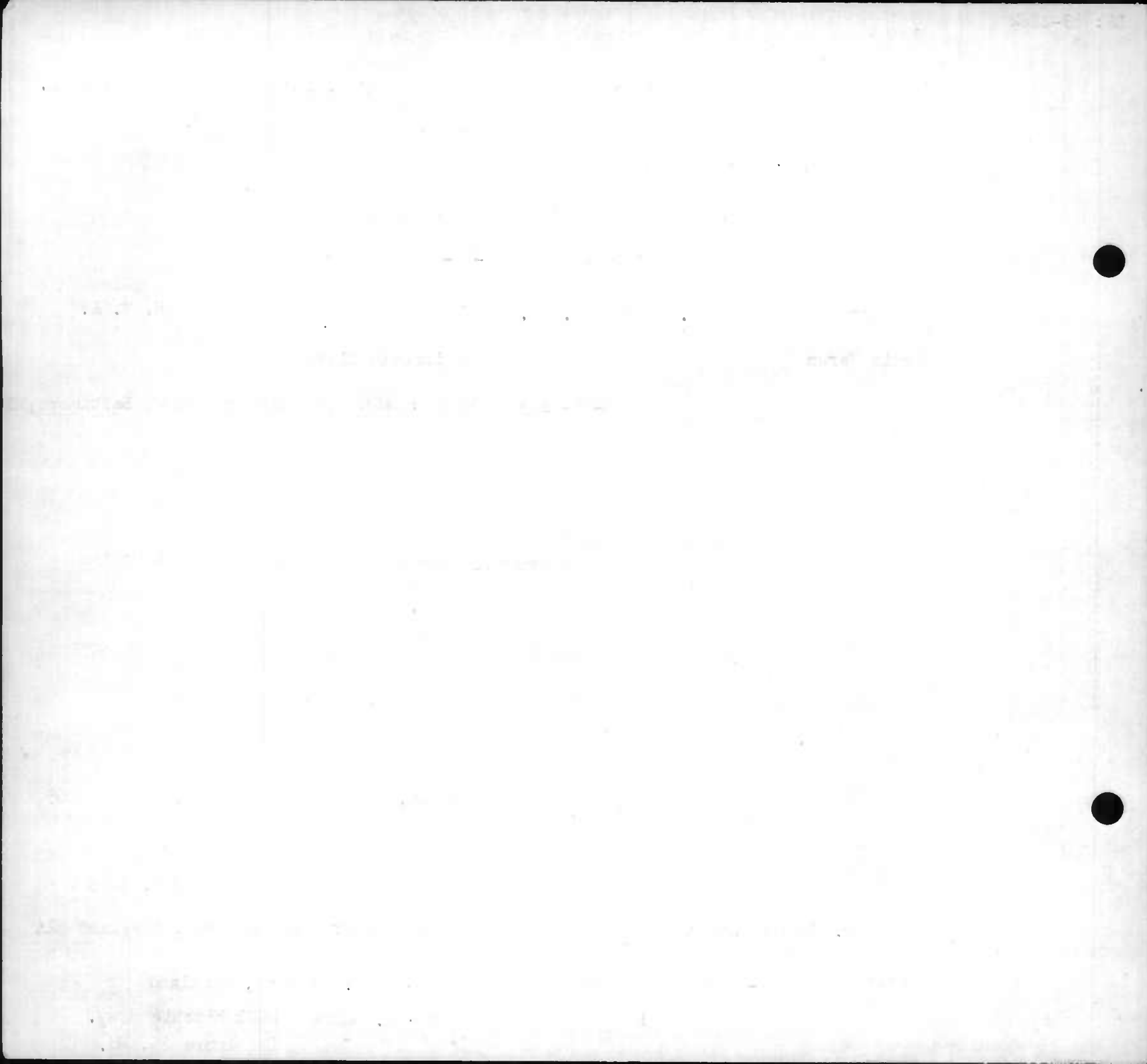
ADDRESS

4001 Ritchie Hgwy.

Baltimore 25, Md.

FUNERAL DIRECTOR: IMPORTANT

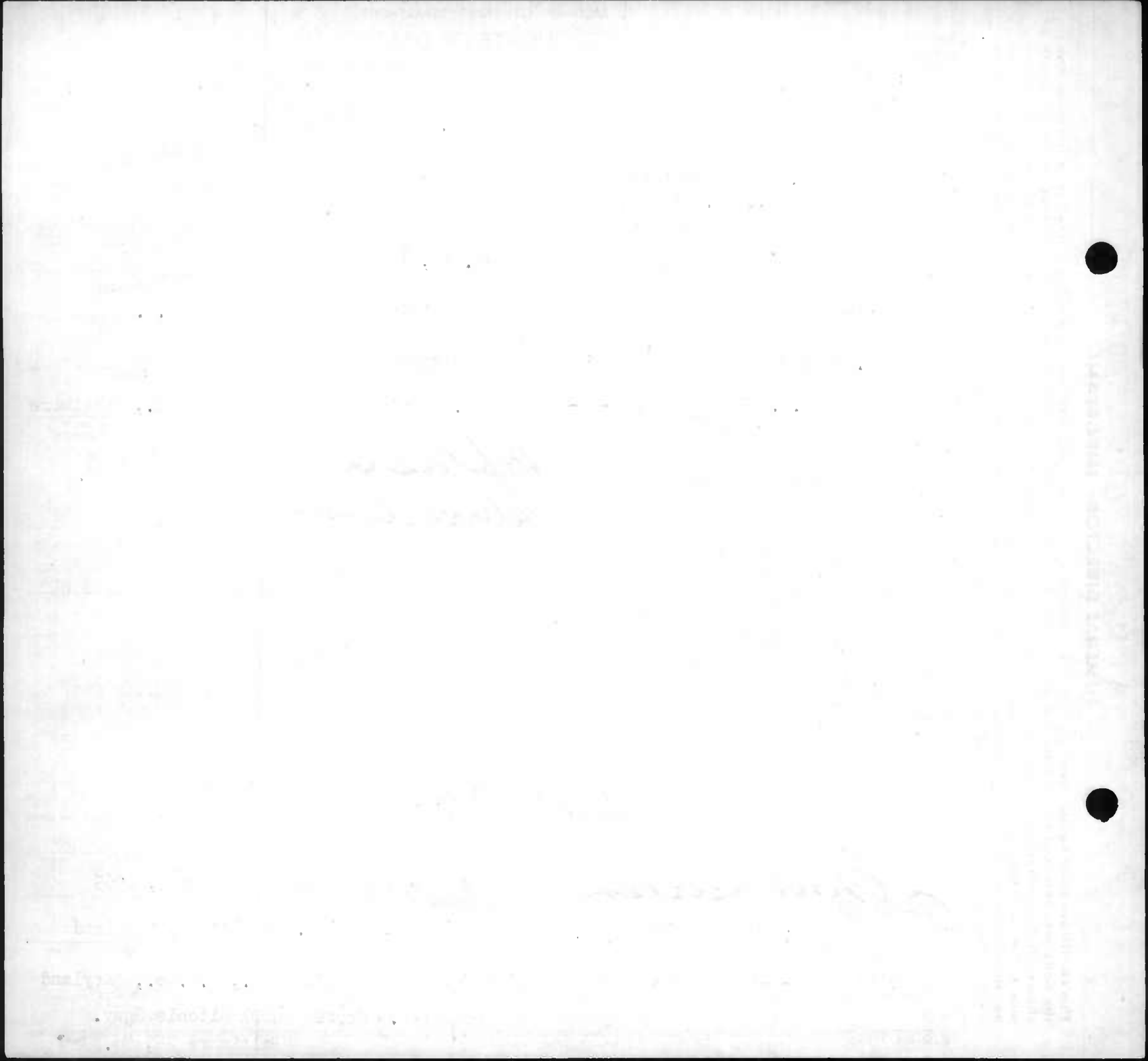
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.5em;">65 4731</span>				
BIRTH NO. <span style="font-size: 1.5em;">65 4731</span>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Kersey, James</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5/1/65 6:50 P.M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">St. Agnes Hospital Balto., Md. 21229</span>					A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">Anne Arundel</span>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Balto.</span>				
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">15 Ballman Ct. 21225</span>				
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">Cauc.</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">M</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Oct. 18, 1907</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">57</span>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Mechanic</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">John O. Kersey</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">unknown</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes W.W. II</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-07-2438</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. Jennie Kersey 15 Ballman Ct., Baltimore</span>				
18. <span style="font-size: 1.5em;">444X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Hypertension</span> <span style="font-size: 1.2em;">Atherosclerosis</span>					INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1959</span>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1959</span> 19 to <span style="font-size: 1.2em;">5/3</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 2</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.5em;">J. Emmett Queen</span>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">May 3, 1965</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. Emmett Queen</span>					23D. ADDRESS <span style="font-size: 1.2em;">Medical Arts Bldg. Baltimore, Maryland</span>				
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-4-1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Glen Haven Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Ritchie Hgwy., A.A.Co., Maryland</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 4 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">George J. Gence</span>		ADDRESS <span style="font-size: 1.2em;">4001 Ritchie Hgwy. Baltimore 25, Md.</span>			

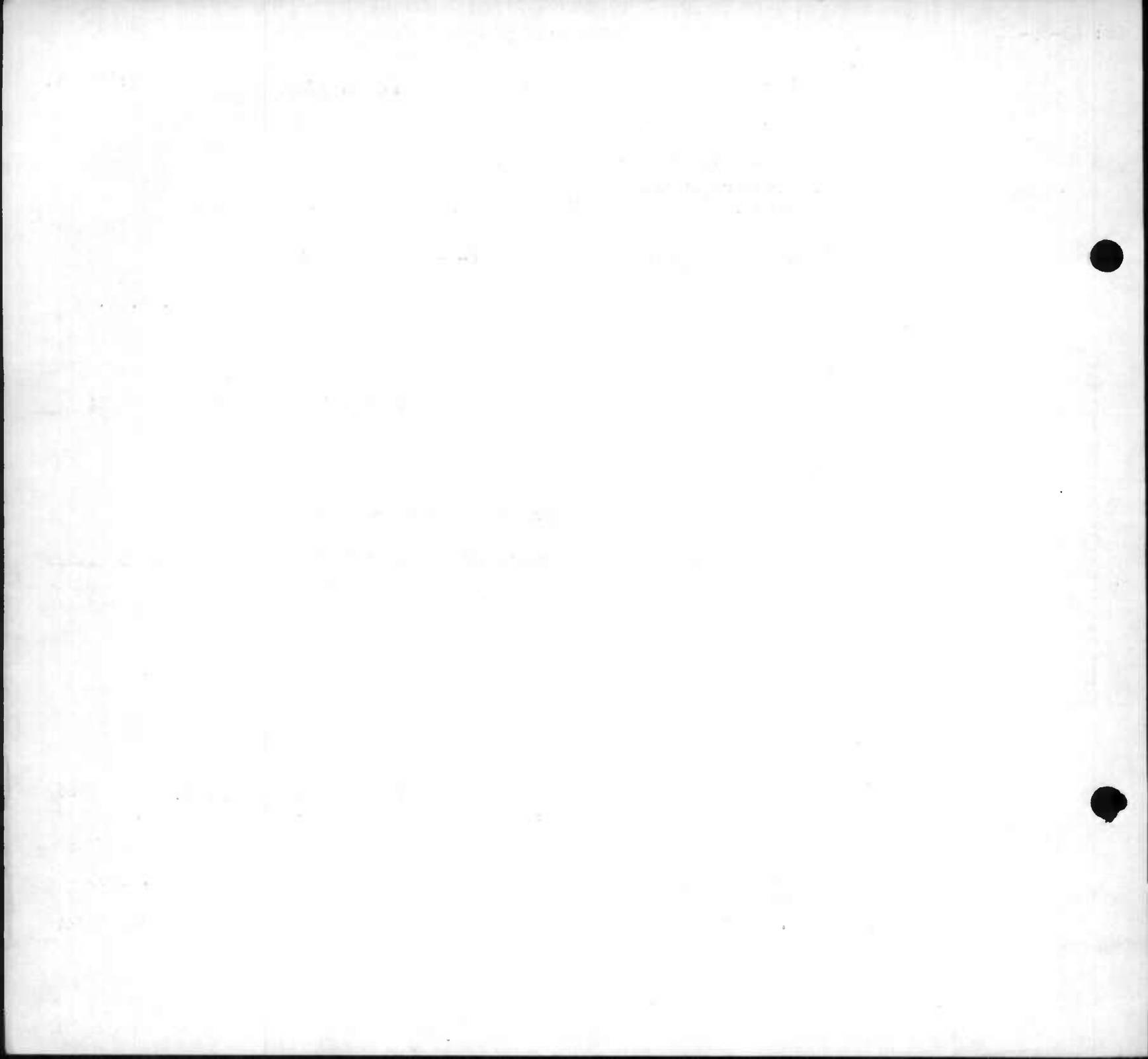


C-55-5-11  
LS: 43-35-11

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4732	
CERTIFICATE OF DEATH					
BIRTH NO. 65 4732					
M.E. CASE NO. A.					
1. NAME OF DECEASED (Type or Print) Mary Cunningham		2. DATE AND HOUR OF DEATH May 2, 1965 7:15 A. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		A. STATE Maryland B. COUNTY 18-03			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	
8. DATE OF BIRTH 6-4-80		9. AGE (In years last birthday) 84		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Byrne			
14. MOTHER'S MAIDEN NAME Jane Ann Hughes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24			
18. 432.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Cerebrovascular Accident (B) DUE TO Arteriosclerotic Cardiovascular Disease 30 Years		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 11, 1964 to May 2, 1965, that (I) (we) last saw the deceased alive on May 2, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Rath		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 2, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Howard Rathbun		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave. St. 23, md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert G. Smith		25C. FUNERAL DIRECTOR J. Howard Smith Inc.	



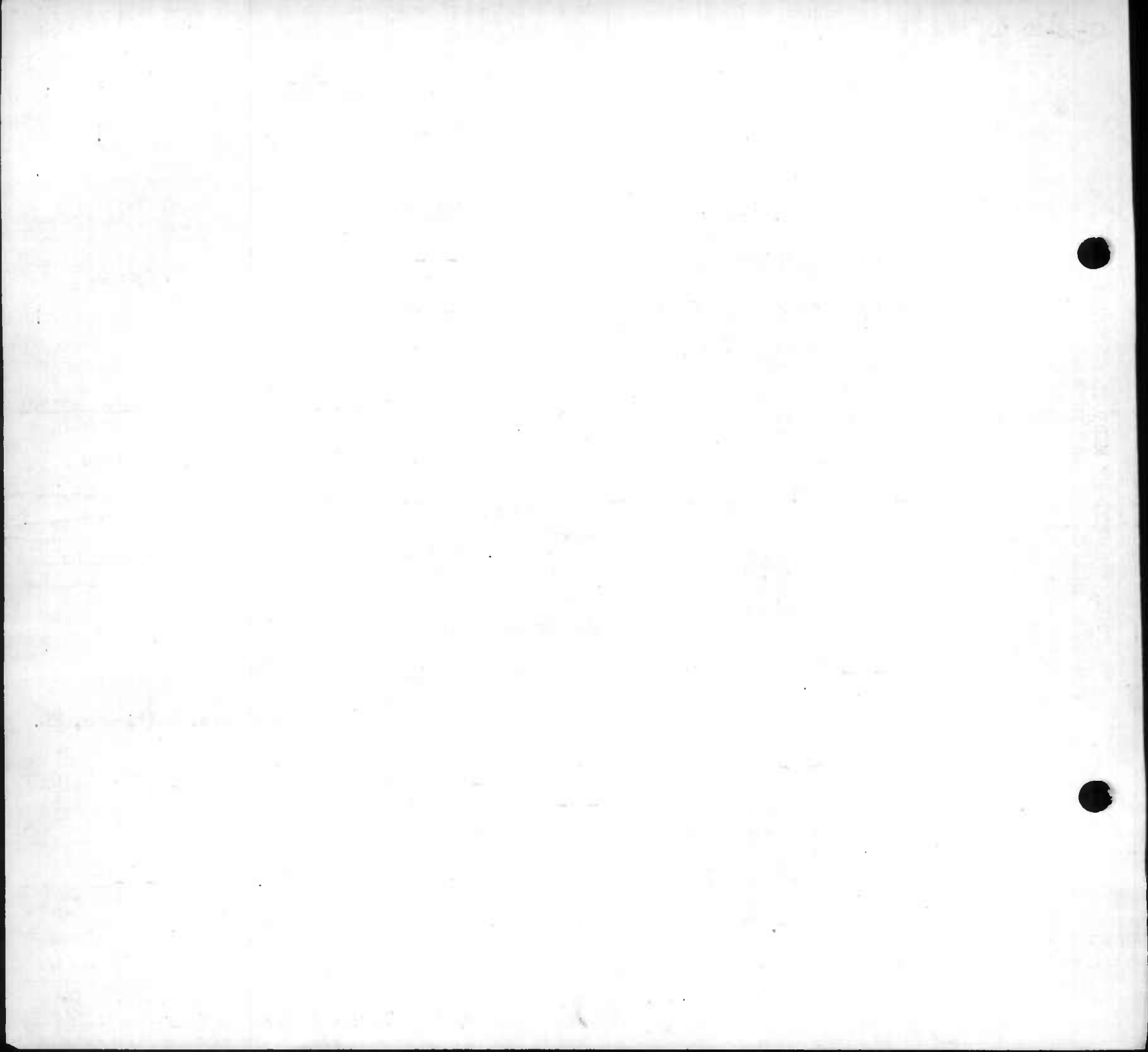


43-35-20 AM

TO BE APPROVED BY MEDICAL EXAMINER  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4733	
BIRTH NO. 65 4733		CERTIFICATE OF DEATH		Registered No. 65 4733	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) (NATALIA) Natalia Gellert		2. DATE AND HOUR OF DEATH 4-29-65 8:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		D. STREET ADDRESS (If rural, give location) 6515 Brook Avenue			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-20-1884	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME HERMAN GELLERT		14. MOTHER'S MAIDEN NAME MARIA KARG	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 Days	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Paralytic Ileus		21. FRACTURE OF (R) Femur		10 Days	
22. Cerebral Vascular Accident		3 Months			
19A. DATE OF OPERATION 3 4-19-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture (R) Femur		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) [X]		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 6515 Brook Avenue, Baltimore, MD.	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 4-11-65		21E. INJURY OCCURRED While At Work [ ] Not While At Work [X]		21F. HOW DID INJURY OCCUR? Patient fell in her own house	
22. I certify that (I) (this hospital) attended the deceased from 4-15 19 65 to 4-29 19 65, that (I) (we) lost saw the deceased alive on 4-29- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4-29-65	
23C. PHYSICIAN'S NAME (Type) Dr. Charles Carpenter				23D. ADDRESS 4940 Eastern Avenue, #21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-3-65		24C. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.	
24D. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD. BA.CO., MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS 901 S. CONKLEING ST. BALTO., MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

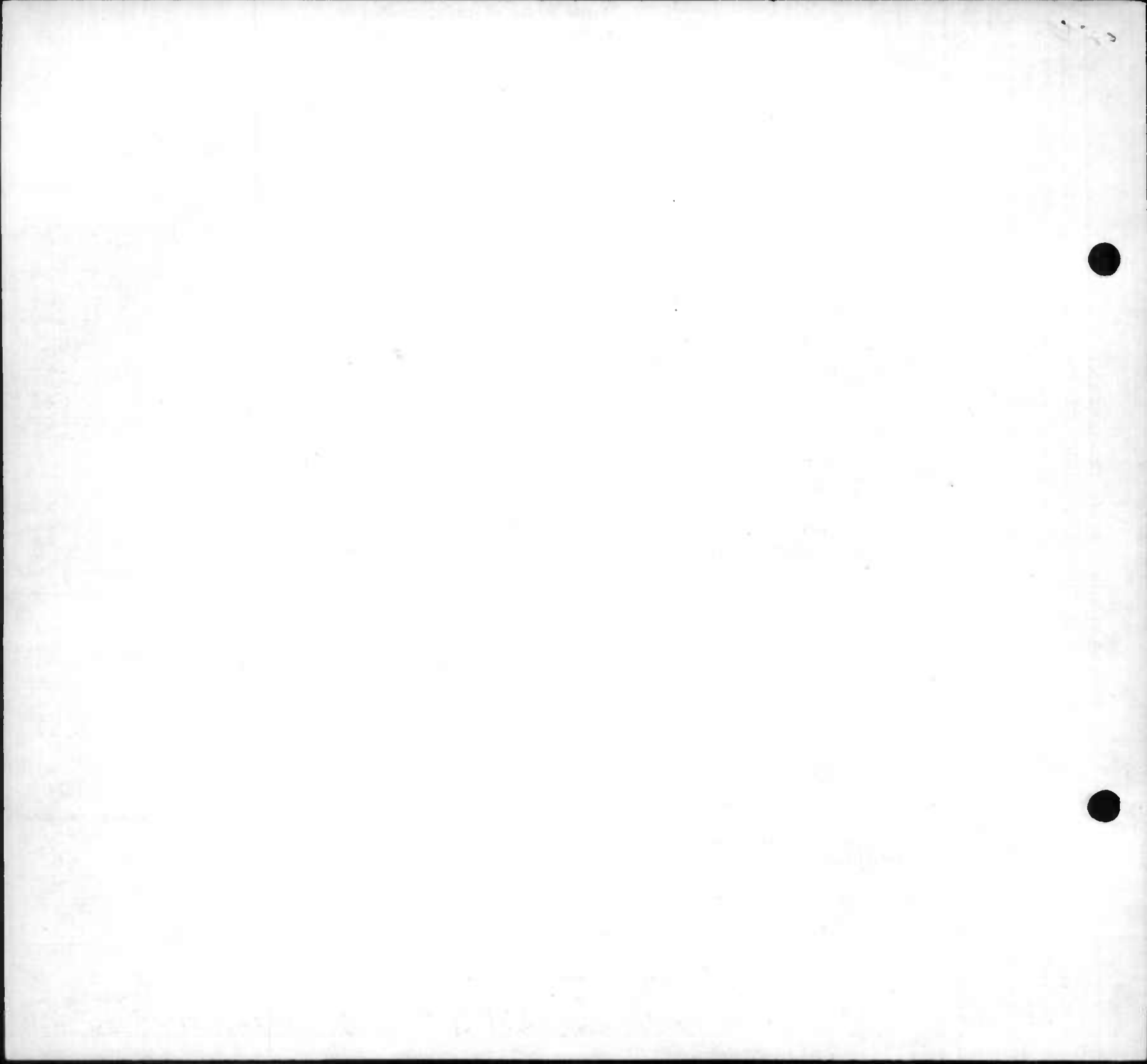
BALTIMORE CITY HEALTH DEPARTMENT													
CERTIFICATE OF DEATH					Registered No. <u>65 4724</u>								
BIRTH NO. <u>65 4734</u>					M.E. CASE NO. <u>65 4734</u>								
1. NAME OF DECEASED (Type or Print) <u>Milton Levy</u>					2. DATE AND HOUR OF DEATH <u>4/29/65 12<sup>18</sup> A M.</u>								
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>27-20</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> D. STREET ADDRESS (If rural, give location) <u>3800 Fallstaff Rd.</u>								
5. SEX <u>MALE</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH	9. AGE (In years) <u>72</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ALBERT LEVY</u>					14. MOTHER'S MAIDEN NAME <u>JOHANNA BENESCH</u>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WW 1 ARMY</u>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. ADELE LEVY 3800 FALLSTAFF RD APT 2A</u>								
<div style="border: 2px solid black; padding: 5px; display: inline-block; transform: rotate(-90deg); transform-origin: center;"> NOT A MEDICAL EXAMINER'S CASE  <u>Charles Levy</u>  CHIEF OR ASST. MEDICAL EXAMINER  <u>4/29/65</u> </div>					18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>					
					ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>11</u>			19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
					OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (I) (this hospital) attended the deceased from <u>DOA on 4/29</u> 19 <u>65</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Lawrence Solomon</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>4/29/65</u>					
23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE Solomon</u>					23D. ADDRESS M.D. <u>Sinai Hospital</u>								
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/2/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>HEBREW FRIENDSHIP</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>							
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1965</u>			25B. NAME OF REGISTRAR <u>Charles Levy</u>			25C. FUNERAL DIRECTOR ADDRESS <u>SQ1 LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

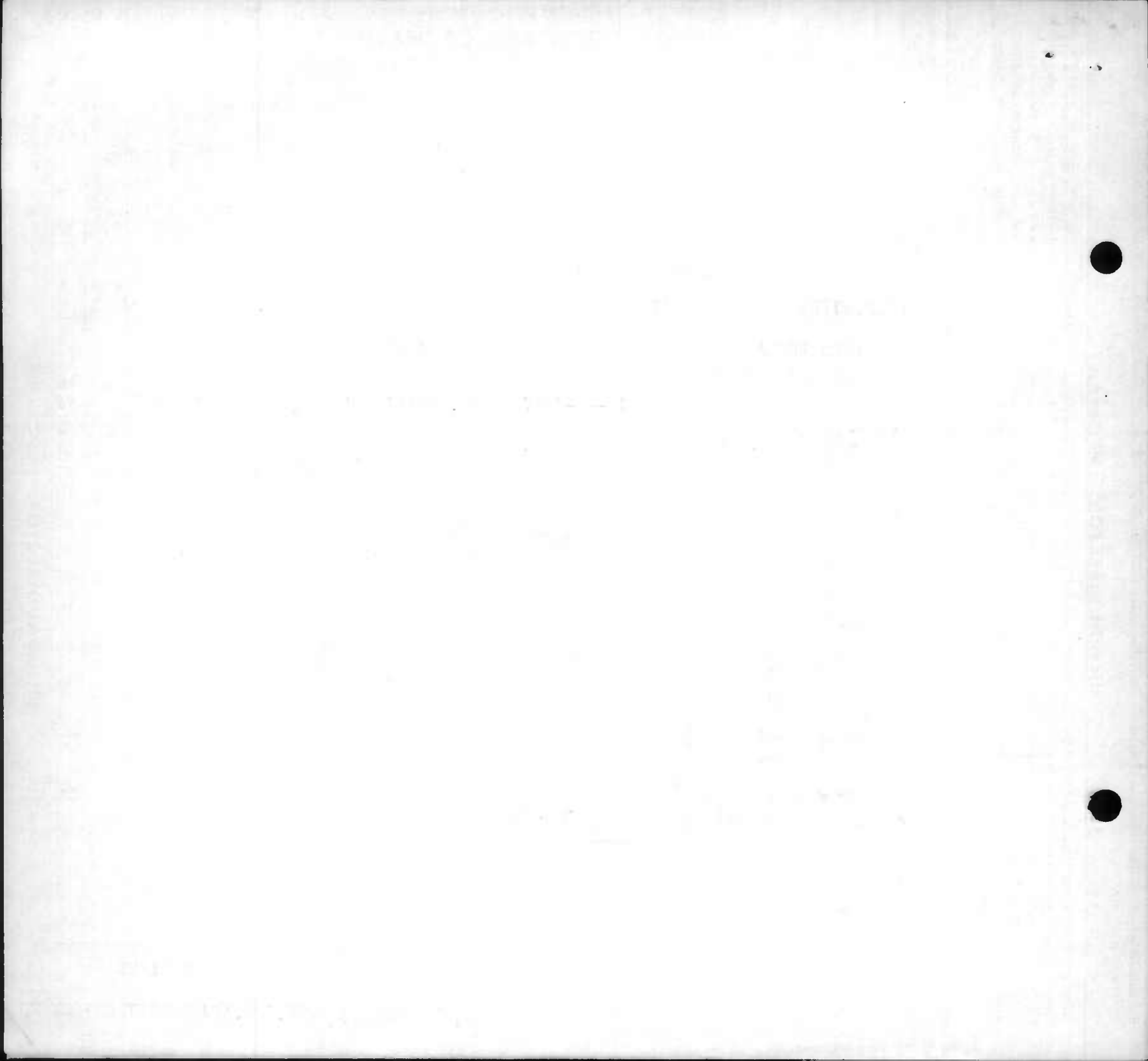
BIRTH NO. 65 4735		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4735	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SCHIFFER, FREDERICK, Joseph		2. DATE AND HOUR OF DEATH 4/30/65 1 15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D-01			
		D. STREET ADDRESS (If rural, give location) 3900 N. CHARLES ST.			
5. SEX M	6. RACE CAUC.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-21-98	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Joseph Schiffer		14. MOTHER'S MAIDEN NAME SARA FUCHS		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 25-32-9252		17. INFORMANT Mrs Catherine Schiffer - 3900 N. Charles	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I		CAUSE OF DEATH (A) Acute Myocardial Infarction (B) Arteriosclerotic Heart Disease (C) Acute Cholecystitis		INTERVAL BETWEEN ONSET AND DEATH 30 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-23 19 65 to 4-30 19 65, that (I) (we) last saw the deceased alive on 4-30 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bruce A. Mallin				23B. DATE SIGNED 4-30-65	
23C. PHYSICIAN'S NAME (Type) BRUCE A. MALLIN		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/65		24C. NAME OF CEMETERY OR CREMATORY Greenwood Mausoleum	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965			
25B. NAME OF REGISTRAR Robert E. Schiffer		25C. FUNERAL DIRECTOR Sol & Winson & Bros		25D. ADDRESS -6010 Rust Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 4736	
BIRTH NO. 65 4736		M.E. CASE NO. 65 4736		1. NAME OF DECEASED (Type or Print) Jennie Kirshner		2. DATE AND HOUR OF DEATH 5-2-65 4:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		A. STATE Md		B. COUNTY 27-20		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto	
		D. STREET ADDRESS (If rural, give location) 5835b. Western Run Dr.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-4-98	9. AGE (In years last birthday) 66	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (State or foreign country) Russia
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME REUBEN PERMAN				14. MOTHER'S MAIDEN NAME SARAH REVA APPLESTEIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-40-1817		17. INFORMANT ADDRESS MRS. MELVIN GLASS 2418 HUNT DRIVE #8			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of the Sigmoid Colon (B) metastatic carcinoma (C) metastasis				INTERVAL BETWEEN ONSET AND DEATH 7 yr	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 4/15 1965 to 5/2 1965, that (1) (we) last saw the deceased alive on 5/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard Gerald Shugartman M.D.				23B. DATE SIGNED 5/2/65			
23C. PHYSICIAN'S NAME (Type) Richard Gerald Shugartman M.D.				23D. ADDRESS Sinai			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/4/65		24C. NAME OF CEMETERY or CREMATORY MIKRO KODESH BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR SQA LEVINSON & BROS. INC. 6010 REISTERSTOWN RD		ADDRESS	

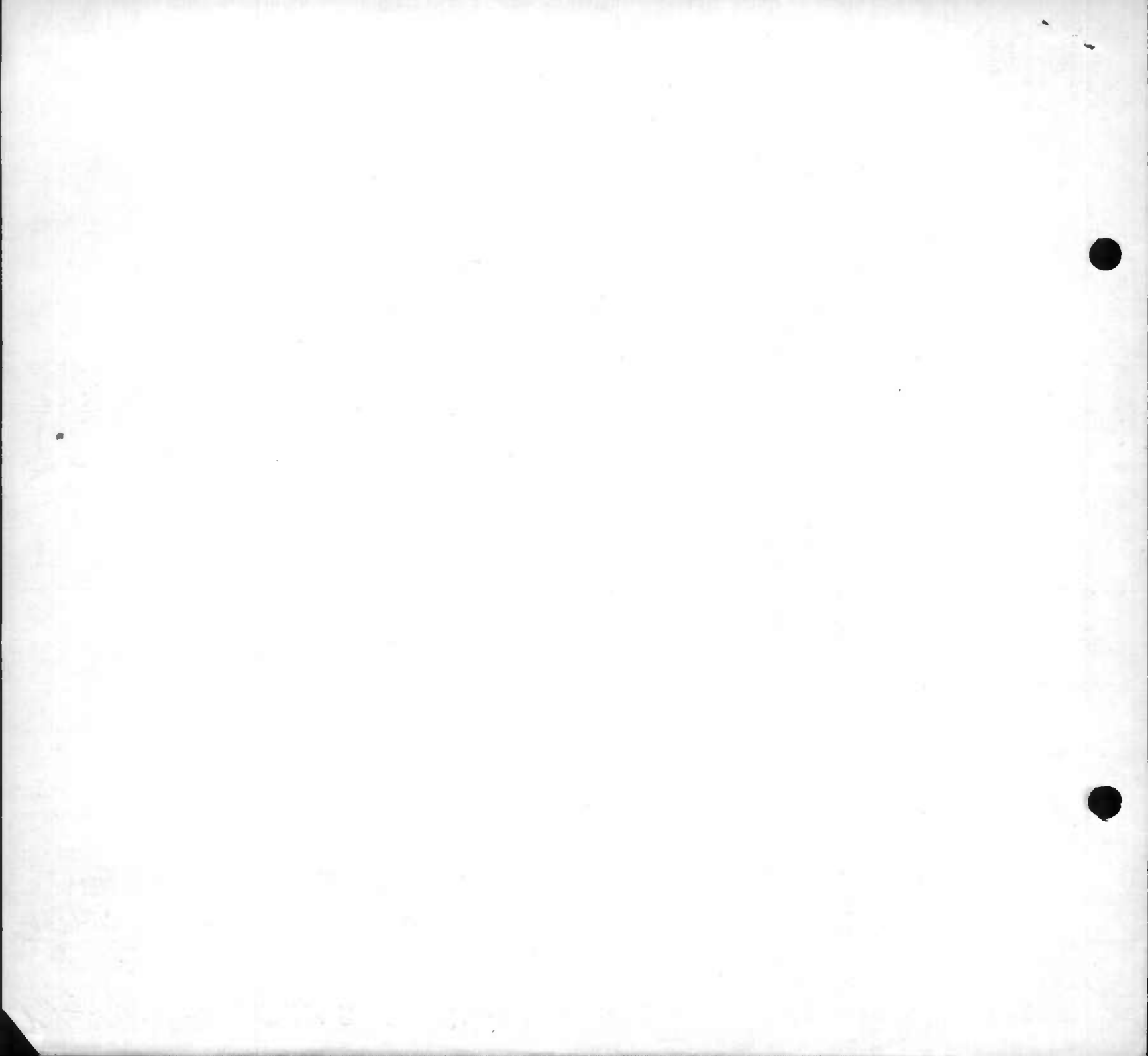




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65 4737						CERTIFICATE OF DEATH			Registered No. 65 4737		
1. NAME OF DECEASED (Type or Print) <i>Rebecca Bloom</i>						2. DATE AND HOUR OF DEATH <i>May 2, 1965 11:30 P.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>6013 Park Heights Ave</i>						A. STATE <i>Maryland</i> B. COUNTY <i>27-20</i>					
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					
						D. STREET ADDRESS (If rural, give location) <i>6013 Park Heights Ave</i>					
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>		8. DATE OF BIRTH <i>Nov 22, 1917</i>		9. AGE (In years last birthday) <i>47</i>		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Medical</i>		11. BIRTHPLACE (State or foreign country) <i>Brooklyn, N.Y.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Late Max Zemel</i>						14. MOTHER'S MAIDEN NAME <i>Dora Rothstein</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-10-9140</i>		17. INFORMANT <i>Harry Zemel - 6013 Park Hts Ave</i>				ADDRESS	
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <i>Cardio-Respiratory Failure</i> DUE TO (B) <i>Ac Myocardial Infarction</i> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Oct 15</i> 19 <i>58</i> to <i>May 2</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>May 2</i> 19 <i>65</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>not</del> ) view the body after death.											
23A. SIGNATURE <i>William D Appleford</i>						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <i>May 3, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>William D Appleford</i>						23D. ADDRESS M.D. <i>5901 Park Heights Dr. Balto 18 Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/3/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Chapel Green</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 4 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i>				25C. FUNERAL DIRECTOR <i>Salvatore Bus - 6001 East</i>			
								ADDRESS			



BIRTH NO.

65

4738

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

4738

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY L. SHEVITZ

2. DATE AND HOUR PRONOUNCED DEAD

5-2-65

1:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SINAI HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3703 SEVEN MILE LANE APT 2A

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

7/21/1895

9. AGE (In years  
last birthday)

69

10. Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PROPRIETOR

10B. KIND OF BUSINESS OR INDUSTRY

FURNITURE STORE

11. BIRTHPLACE (State or foreign country)

LITHUANIA

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

PHILIP SHEVITZ

14. MOTHER'S MAIDEN NAME

YETTA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. ANNA SHEVITZ 3703 SEVEN MILE LANE APT 2A

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Hypertensive cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-2-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5/4/65

23C. NAME of CEMETERY or CREMATORY

AITZ CHAIM

23D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

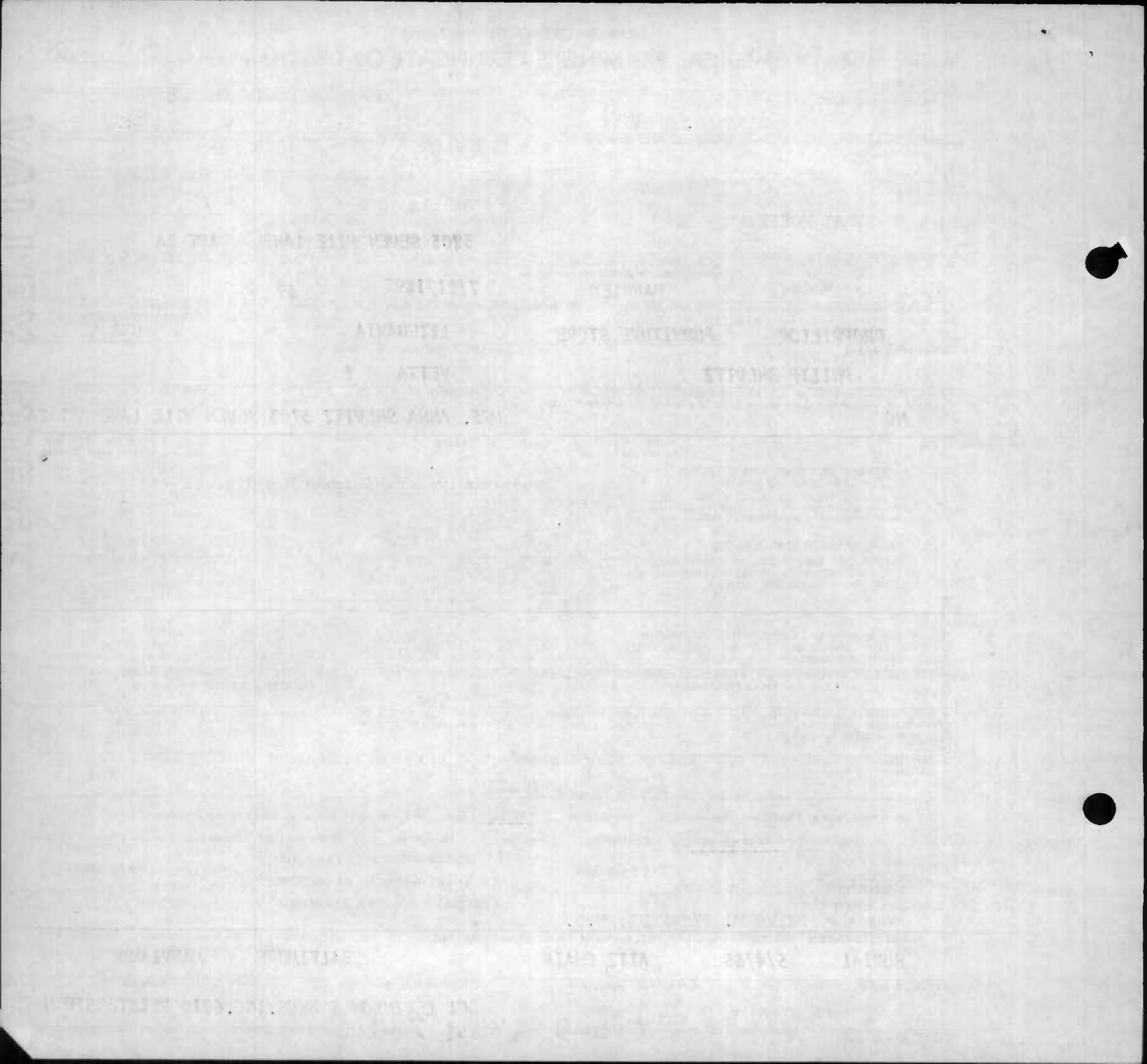
24C. FUNERAL DIRECTOR

ADDRESS

MAY 4 1965

Peter W. Rieckert, M.D.

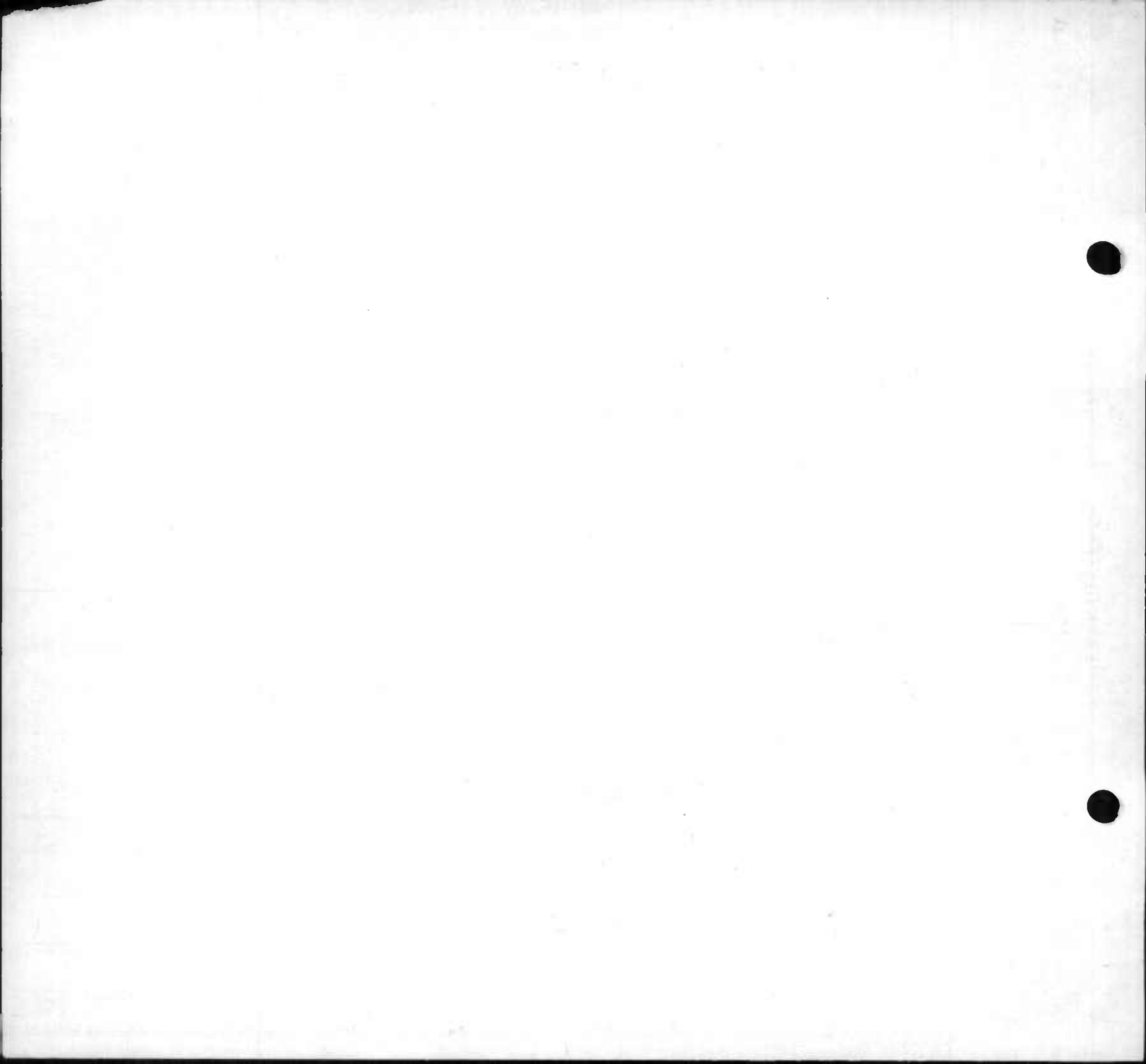
SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

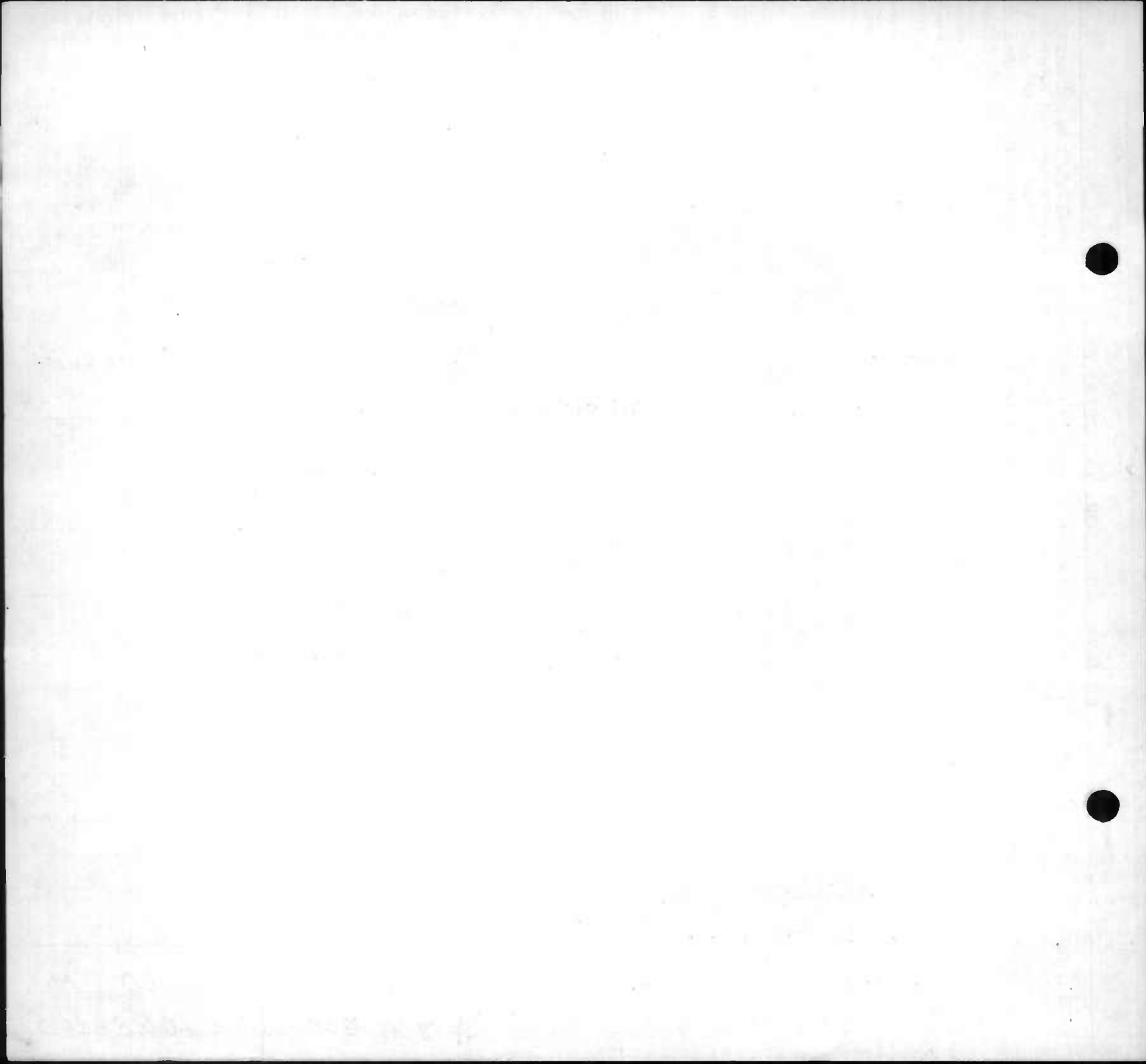
BIRTH NO. 65 4739		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 4739	
1. NAME OF DECEASED (Type or Print) <b>Ompre or Onufred Hodulka</b>		2. DATE AND HOUR OF DEATH <b>5/3/65</b> <b>4<sup>30</sup> A M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5300 1243 Rumore ave</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8/10/1899</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BETH STEEL CO</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>? PETER HODULKA</b>		14. MOTHER'S MAIDEN NAME <b>? UNK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>213-07-1510</b>		17. INFORMANT <b>George D. Lawrence, MD</b>	
18. <b>43011</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiogenic Shock</b>		CAUSE OF DEATH (A) <b>Myocardial Infarction</b> (B) <b>Cardiogenic Shock</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> 19 <b>65</b> to <b>5/3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George D. Lawrence</b> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/3/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE D LAWRENCE</b> M.D.		23D. ADDRESS <b>University Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY TRINITY CEM</b>	
24D. LOCATION (City, town, or county) (State) <b>ELKRIDGE MD</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>1800 E LOMBARD ST</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4740		CITY OF BALTIMORE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH		Registered No. 65 4740	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>BARTKOWIAK, LUCILLE, L. (or) Frances</u>			2. DATE AND HOUR OF DEATH <u>5/3/65</u> <u>12<sup>20</sup> P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>			A. STATE <u>MD</u> B. COUNTY <u>2-02</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>		
			D. STREET ADDRESS (If rural, give location) <u>113 S. DURHAM ST</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>12/6/10</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (State or foreign country) <u>? BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES WENZEL KOLLER</u>			14. MOTHER'S MAIDEN NAME <u>MARY FREBURGER FREIDBERGER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 059474</u>	17. INFORMANT ADDRESS <u>UMH CHART</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>204.01</u> <u>PULMONARY EDEMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>SEVERE ANEMIA</u>			<u>6 MO.</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>			<u>6 YR.</u>		
II					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>5/2/1965</u> to <u>5/3/1965</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>5/3/1965</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) (did not) view the body after death.					
23A. SIGNATURE <u>A. Laird Bryson</u>				23B. DATE SIGNED <u>5/3/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. Laird Bryson, M.D.</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>MAY 6 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEM</u>	
24D. LOCATION <u>4430 BELAIR RD MD</u>		24E. LOCATION (City, town, or county) (State) <u>MD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1800 E LOMBARD ST</u>	



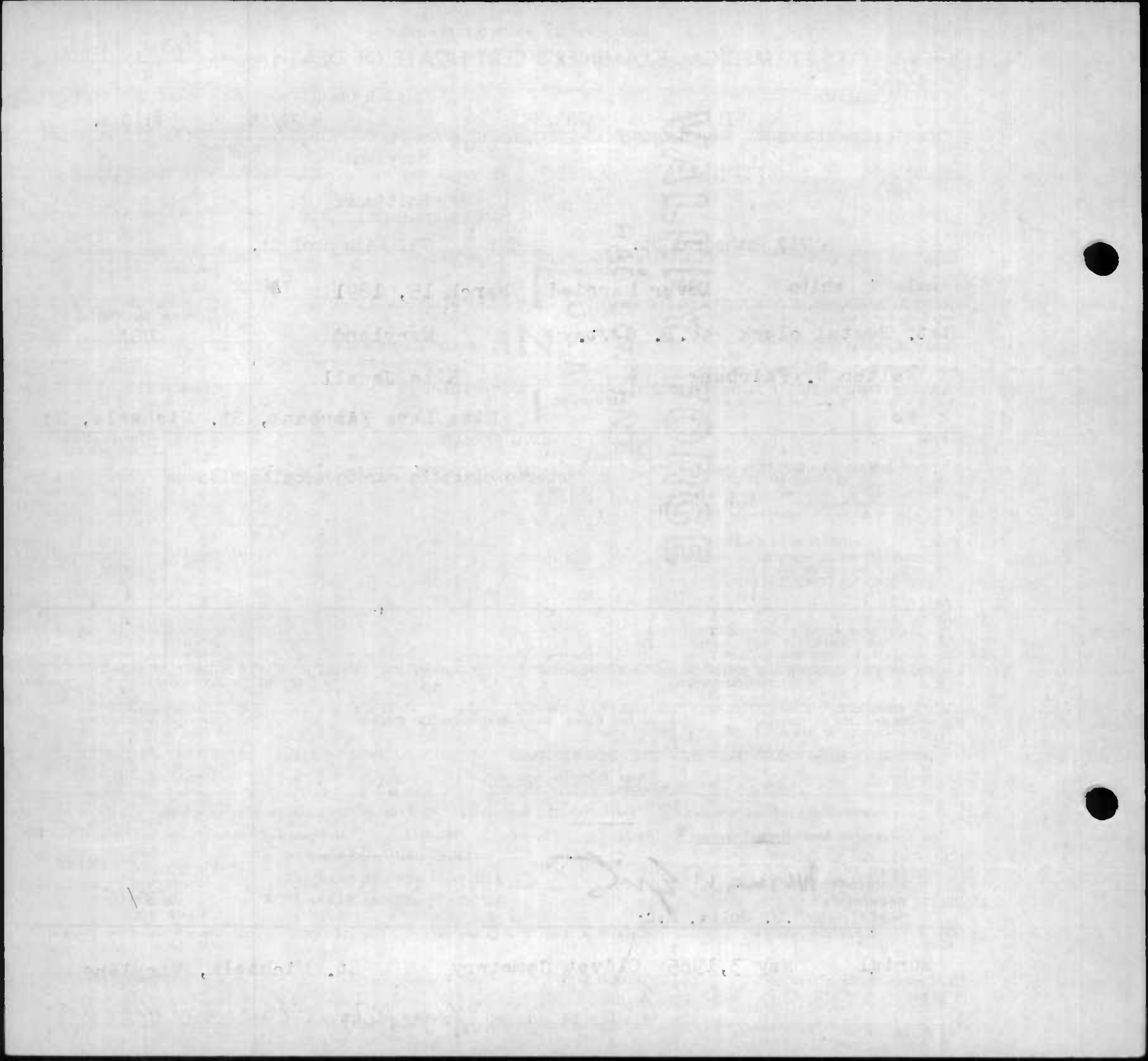


BIRTH NO. **85 4741**  
M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

**65 4741**

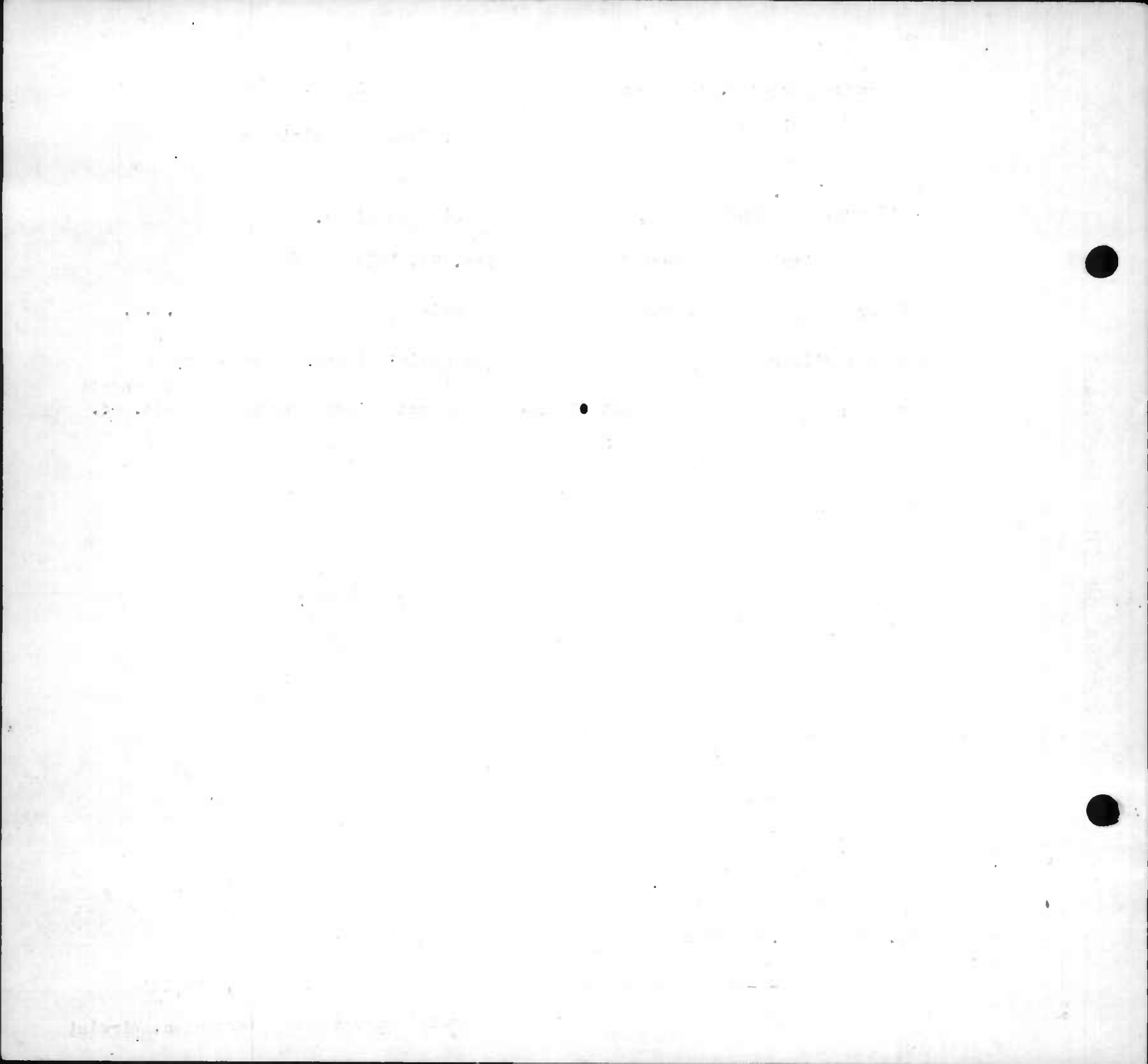
1. NAME OF DECEASED (Type or Print) <b>MILLARD FAIRBANKS</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>4/30/65 2:10 p.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>712 Cathedral St.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>712 Cathedral St.</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>March 15, 1891</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Postal clerk</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Walter W. Fairbank</b>				14. MOTHER'S MAIDEN NAME <b>Ella Jewell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown), (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss Lena Fairbank, St. Michaels, Md</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>W. U. Spitz, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/30/65</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>May 3, 1965</b>		23C. NAME of CEMETERY or CREMATORY <b>Clivet Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>St. Michaels, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Fairbank, M.D.</b>		24C. FUNERAL DIRECTOR <b>St. Michaels</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>65 4742</b>	
BIRTH NO. <b>65 4742</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Baron Yurgen Z. von Stackelberg</b>		2. DATE AND HOUR OF DEATH <b>April 30, 1965</b> <b>10:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  <b>residence</b> FULL NAME OF HOSPITAL OR INSTITUTION <b>304 Kendall Rd. Baltimore, Maryland</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>304 Kendall Rd.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 27, 1902</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Alexander Zilberg</b>			14. MOTHER'S MAIDEN NAME <b>Valentine Zilberg Stackelberg</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214 01 3196</b>		17. INFORMANT ADDRESS <b>Margaret Holmes Stackelberg Balt. Md.</b>		
18. <b>137 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cancer of Prostate</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Cancer of Prostate</b> (B) <b>Due to</b> (C) <b>Due to</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>Apr 30 1965</b> that (I) (we) last saw the deceased alive on <b>Apr 30 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William G. Helfrick</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>May 1st 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. William G. Helfrick</b>				23D. ADDRESS <b>5006 Roland Ave Balto 10 Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Warrenton</b>		24D. LOCATION (City, town, or county) (State) <b>Warrenton, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Mosey Funeral Home Warrenton, Virginia</b>	



1

65 4743

BALTIMORE CITY HEALTH DEPARTMENT

65 4743

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERKLEY E. SCOTT

2. DATE AND HOUR PRONOUNCED DEAD

April 21, 1965 6:25 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

426 E. Pratt St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 322.17 002.1  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Chronic ethylism  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Pulmonary tuberculosis (by history)

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-21-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY OR CREMATORY

23D. DEACON (If in town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

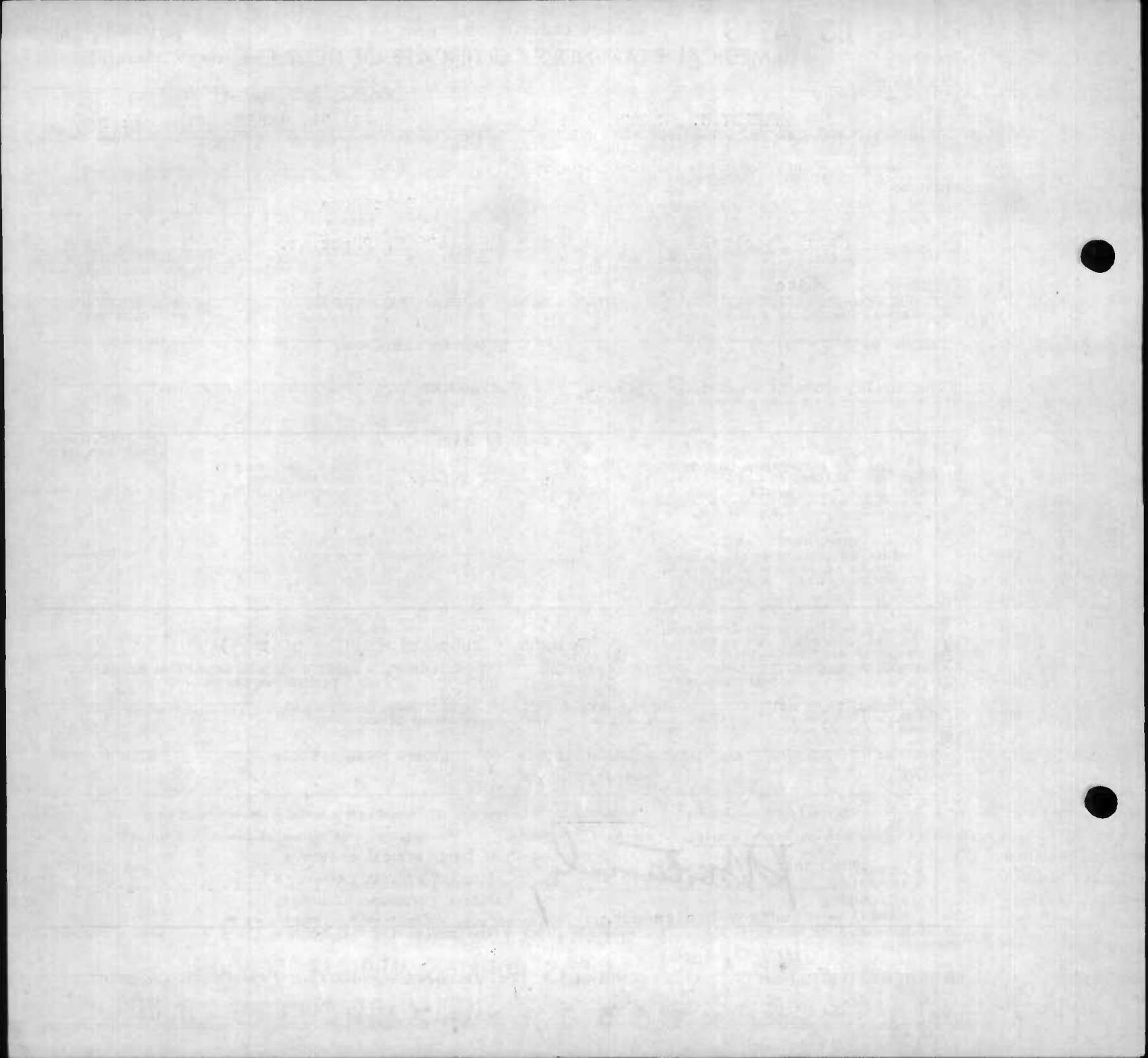
24C. FUNERAL DIRECTOR

ADDRESS

MAY 4 1965

Rudiger E. Breitenacker

MORTUARY SERVICE - BCHD





BIRTH NO.

65 4744

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 4744

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM T. BROOKS

2. DATE AND HOUR PRONOUNCED DEAD

4-12-65

9:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1115 E. Pratt Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1115 E. Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) ~~XXXXX~~ Pulmonary emphysema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fatty liver  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☒DATE SIGNED  
4-12-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 3 1965

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 4 1965

Peter W. Rieckert, M.D.

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

WALLACE FONRO



1  
R-200

65 4745

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4745

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BRUCE RACEY

2. DATE AND HOUR PRONOUNCED DEAD

April 14, 1965

10:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

510 W. Fayette St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

510 W. Fayette St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive cardiovascular disease  
and fatty metamorphosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-14-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 3 1965

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

City, town, or county

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL

ADDRESS

MORTUARY SERVICE - BCHD

WALLEY FORGE

WALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4746	
BIRTH NO.				65 4746	
M.E. CASE NO.				65 4746	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Gray, James W.				May 1, 1965 1:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  Provident Hospital				Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2036 Ruxton Avenue #17	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	
Male		Negro		Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreman		Hospital Employee		Baltimore, Md	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
ERNEST GRAY				BESSIE WALLACE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes WW II		220-14-7516		MRS OWEN GRAY 2016 Mc KEAN Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
I 332X Cerebral Thrombosis				(A) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO	
(C) DUE TO				(C) DUE TO	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<input type="checkbox"/>					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-29-1965 to 5-1-1965, that (I) (we) last saw the deceased alive on 5-1-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Roger Theodore				5-1-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Roger Theodore				Provident Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		5/5/65		Baltimore National Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 4 1965		Robert E. Fairbank		Joseph L. Lyles 2222 W North Ave 21214	

July 1, 1955

July 1, 1955

Dear Mr. [illegible]

Enclosed is [illegible]

Very truly yours,

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

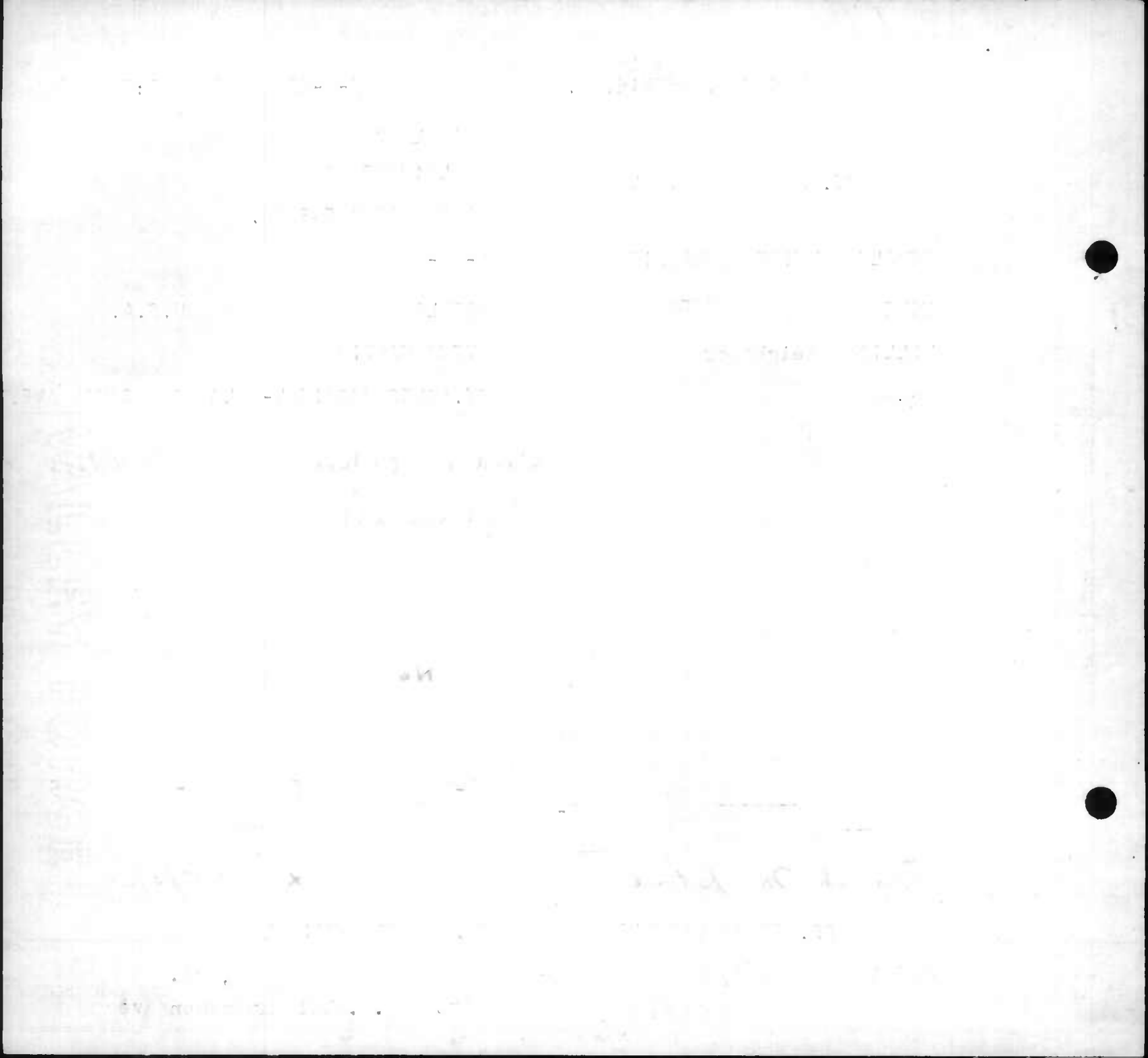
[illegible]

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

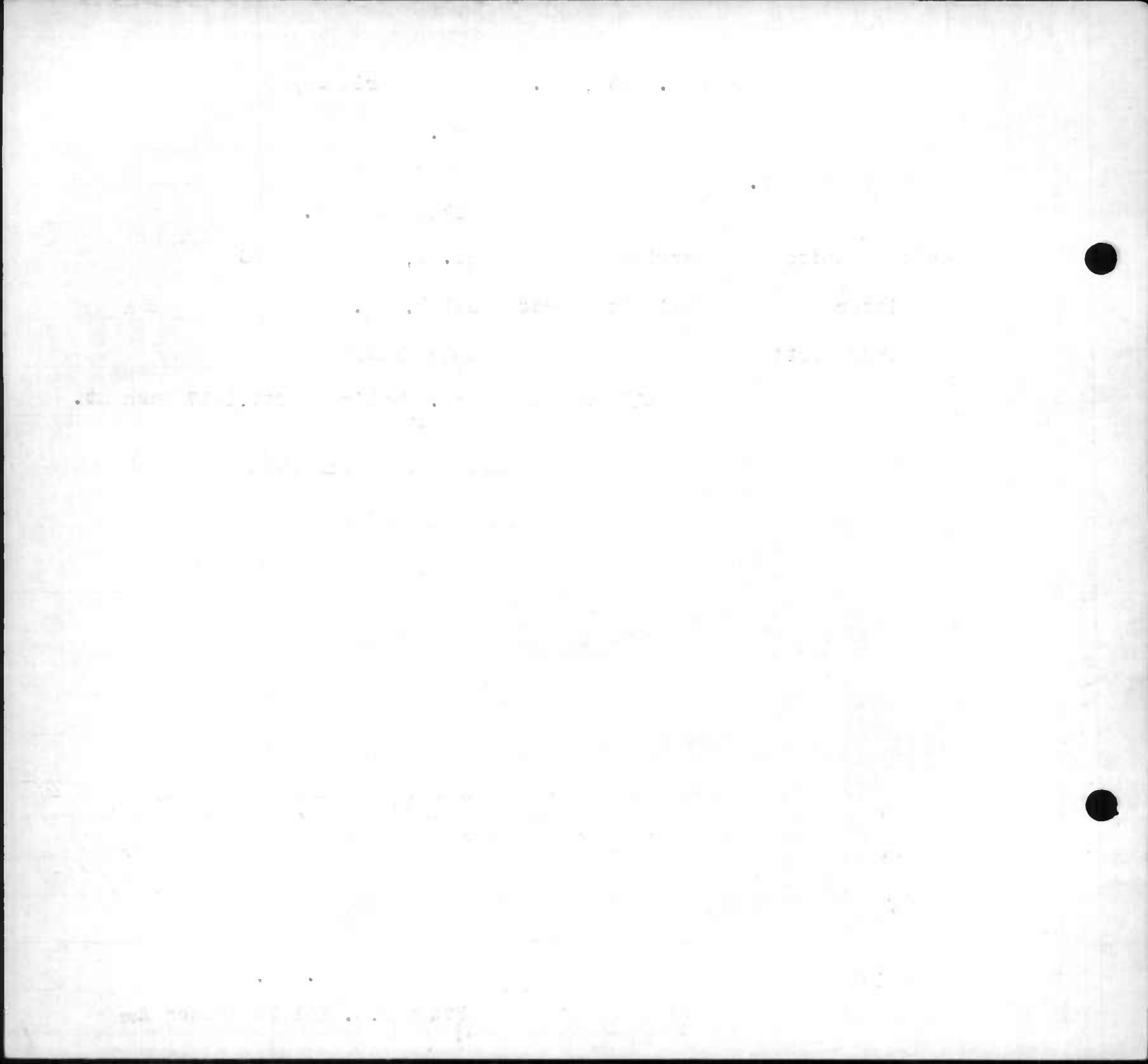
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 2em;">③</span> 65 4747		CERTIFICATE OF DEATH		Registered No. 65 4747	
1. NAME OF DECEASED (Type or Print) <b>Mettie WACHTER, Mettler, E.</b>						2. DATE AND HOUR OF DEATH <b>5-2-65 13:50 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE 29</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 29</b> D. STREET ADDRESS (If rural, give location) <b>4647 MANORDENE RD.</b>			
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>2-27-88</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM Reightler</b>						14. MOTHER'S MAIDEN NAME <b>TENA MARTIN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL-WILKENS &amp; CATON AVE.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <b>Cardiac failure</b> DUE TO (B) <b>Septicemia (Pseudomonas)</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4-27</b> 19 <b>65</b> to <b>5-2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5-2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Frank M. Detorie</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. FRANK DETORIE</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore 7, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4748					65 4748				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Joseph M. Gortt, Sr.					April 30/65 10.30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION  1517 Bush St.					A. STATE Md. B. COUNTY 21-02				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 1517 Bush St.				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Oct. 6, 1908		9. AGE (In years last birthday) 56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fitter		10B. KIND OF BUSINESS OR INDUSTRY Ellicott Brandt		11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Gortt					14. MOTHER'S MAIDEN NAME Lula Kelly				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 216 09 9543		17. INFORMANT Mrs. Pauline Gortt, 1517 Bush St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH I 163X I Carcinoma left lung INTERVAL BETWEEN ONSET AND DEATH 6 months					(A) DUE TO				
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 10/19/65 to 4/30/65, that (I) (we) last saw the deceased alive on 4/30/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE John P. Urlock, Jr.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/4/65		
23C. PHYSICIAN'S NAME (Type) JOHN P. URLOCK JR.					23D. ADDRESS 1227 Wash. Blvd				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 4/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park			24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Witzke F.D.			ADDRESS 4101 Edmondson Ave	





65 4749

BALTIMORE CITY HEALTH DEPARTMENT

65 4749

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LILLIAN P. Brewington

2. DATE AND HOUR PRONOUNCED DEAD

5-2-65

3:35 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE CORRECTED

5-10-65

HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
ADDRESS OR LOCATION)

300 E. 28TH STREET

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

300 E. 28th Street 21218

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

2/6/1883

9. AGE (In years  
last birthday)

82

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clinton Parry

14. MOTHER'S MAIDEN NAME

Emma L. Ingram - M. Louisa Ingram

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
3607 Greenmount Ave.  
Miss Edna L. Parry Baltimore, Md. 18

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/5/65

23C. NAME OF CEMETERY or CREMATORY

Lorraine Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Woodlawn, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. F. Fickner &amp; Sons

ADDRESS

Baltimore, Md. 21217  
north & Pa. ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

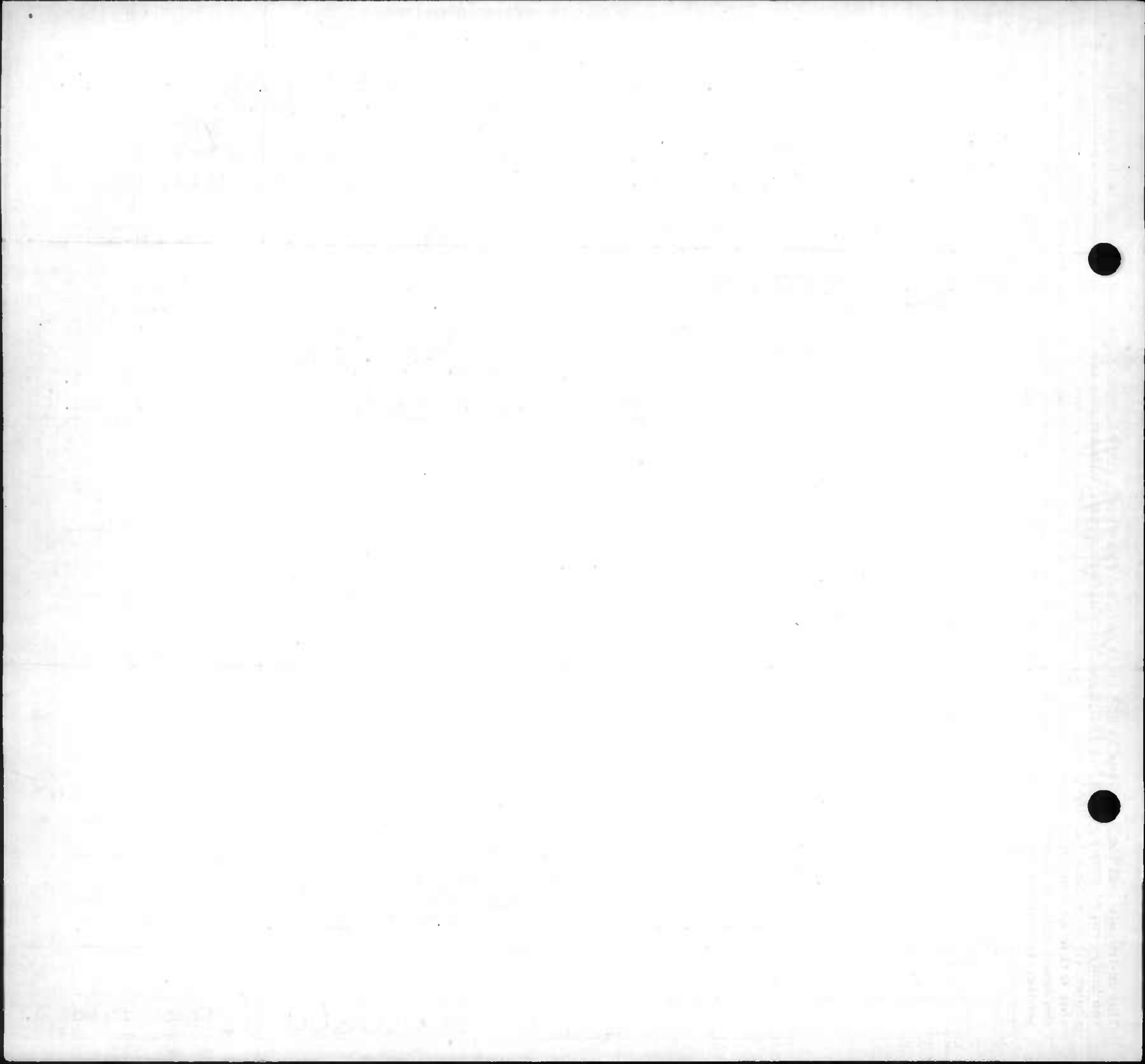
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 4750</u>	
BIRTH NO. <u>65 4750</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Carrie Wilhemina Seim</u>		2. DATE AND HOUR OF DEATH <u>May 3, 1965 2:45 P.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospit</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u>		B. COUNTY <u>12-02</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>3048 Guilford Ave 18</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u>	8. DATE OF BIRTH <u>6-24-83</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Worked</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME <u>John C. Seim</u>			14. MOTHER'S MAIDEN NAME <u>Katharine Repp</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Alvina Seim Baltimore, Md.</u>		
			ADDRESS <u>3048 Guilford Avenue 21218</u>				
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Congestive Heart Failure</u>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>was</del> <u>is</u> ) attended the deceased from <u>4-8-65</u> 19 <u>65</u> to <u>5-3</u> 19 <u>65</u> , that (I) ( <del>was</del> <u>is</u> ) last saw the deceased alive on <u>5-3</u> 19 <u>65</u> and that in ( <del>my</del> <u>my</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> <u>is</u> ) ( <del>did</del> <u>did not</u> ) view the body after death.							
23A. SIGNATURE <u>Charles L. Fletcher</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>May 3, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES L. FLETCHER</u> M.D.				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/6/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St Paul's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Violtville Baltow Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Johnson + Sons</u> ADDRESS <u>Balto, Md. 21217 North + Pa. Aves.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4751	
CERTIFICATE OF DEATH				Registered No. _____	
BIRTH NO. 65 4751		M.E. CASE NO.		2. DATE AND HOUR OF DEATH April 29, 1965 7:15 P.M.	
1. NAME OF DECEASED (Type or Print) Ida R. Willis		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1908 Sulgrave Ave.			
5. SEX female		6. RACE white		8. DATE OF BIRTH 10/15/1877	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed		9. AGE (In years last birthday) 87		10. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Beck	
14. MOTHER'S MAIDEN NAME Mary E. Garrett		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 222 03 1812 B	
17. INFORMANT 1908 Sulgrave Ave. B. Jessie Gooding		18. CAUSE OF DEATH Cancer of Lung INTERVAL BETWEEN ONSET AND DEATH			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, generalized			
21A. DATE OF OPERATION 0		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. AUTOPSY? (Yes or No)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from August 19 64 to April 19 65, that (I) (we) last saw the deceased alive on April 28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE William G. Helfrich M.D.		23B. DATE SIGNED 4/30/65	
23C. PHYSICIAN'S NAME (Print) William Helfrich		23D. ADDRESS 5006 Roland Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/65		24C. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
24D. LOCATION (City, town, or county) (State) Chestertown, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR J. Wells		25D. ADDRESS Chestertown, Md.			



FR

65 4752

## BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

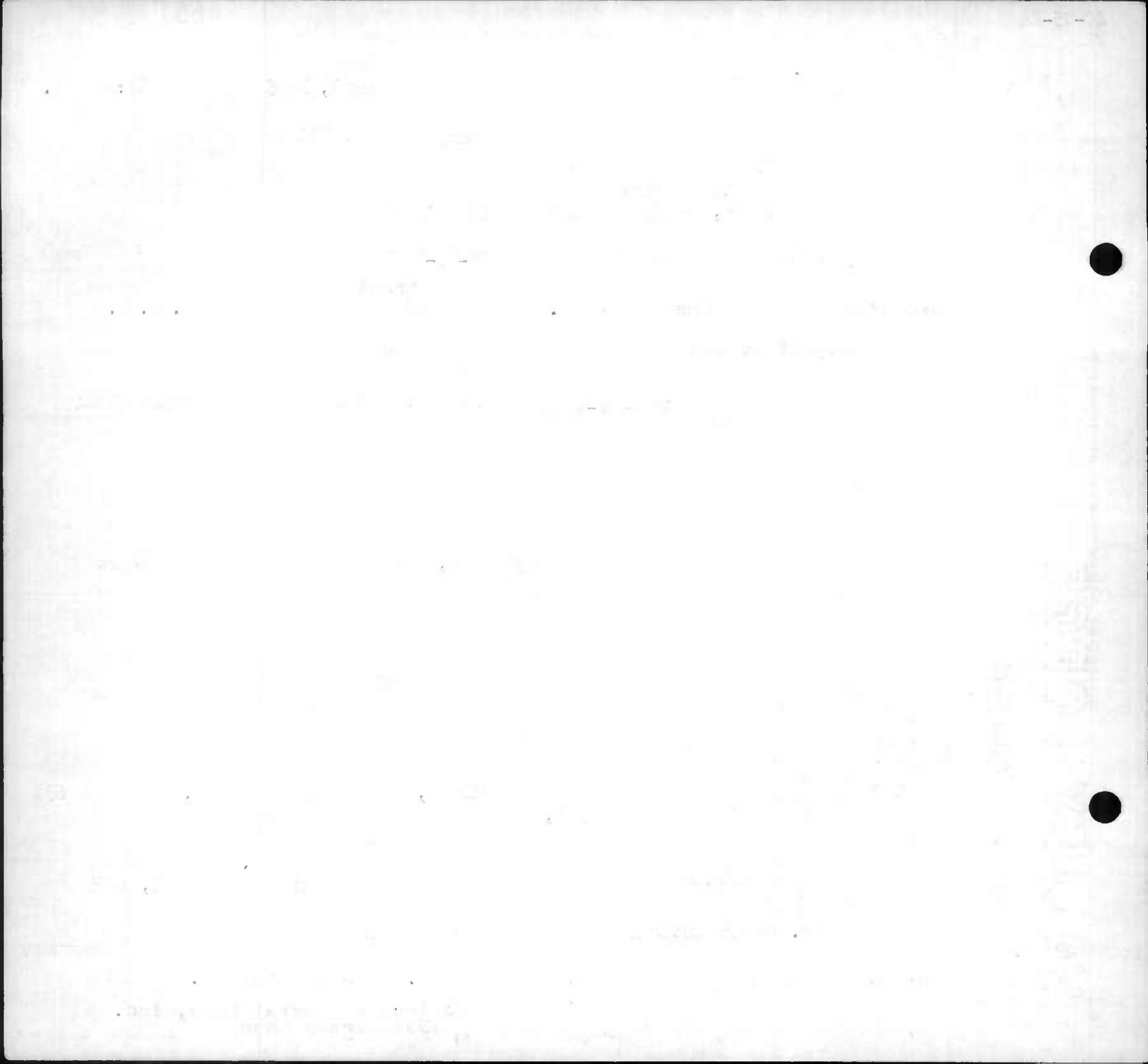
Registered No.

65 4752

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 1.2em;">65 4752</span>		CERTIFICATE OF DEATH		Registered No. _____	
M.E. CASE NO.					
1. NAME OF DECEASED <b>A.</b> (Type or Print) <b>Ross Scheel</b>		2. DATE AND HOUR OF DEATH <b>May 1, 1965</b>		<b>11:50 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL</b>			
		D. STREET ADDRESS (If rural, give location) <b>10 Glider Drive 21220</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-15-1891</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days:    If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lee Metal Co.</b>		11. BIRTHPLACE (State or foreign country) <b>New Market Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>August Scheel</b>		14. MOTHER'S MAIDEN NAME <b>Emma Poole</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>160-01-2910</b>		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>	
18. <b>527.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH  (A) _____ DUE TO  (B) _____ DUE TO  (C) <b>Emphysema, Pulmonary</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>10 Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 27, 19 65</b> to <b>May 1, 19 65</b> that (I) (we) lost saw the deceased alive on <b>May 1, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <b>Dr. Howard Rathbun</b>				23B. DATE SIGNED <b>May 1, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Howard Rathbun</b>				23D. ADDRESS <b>4940 Eastern Avenue 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith Cem.</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>			
25B. NAME OF REGISTRAR <b>E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>Schimmunek Funeral Home, Inc.</b>			
25D. ADDRESS <b>3331 Brehms Lane</b>					

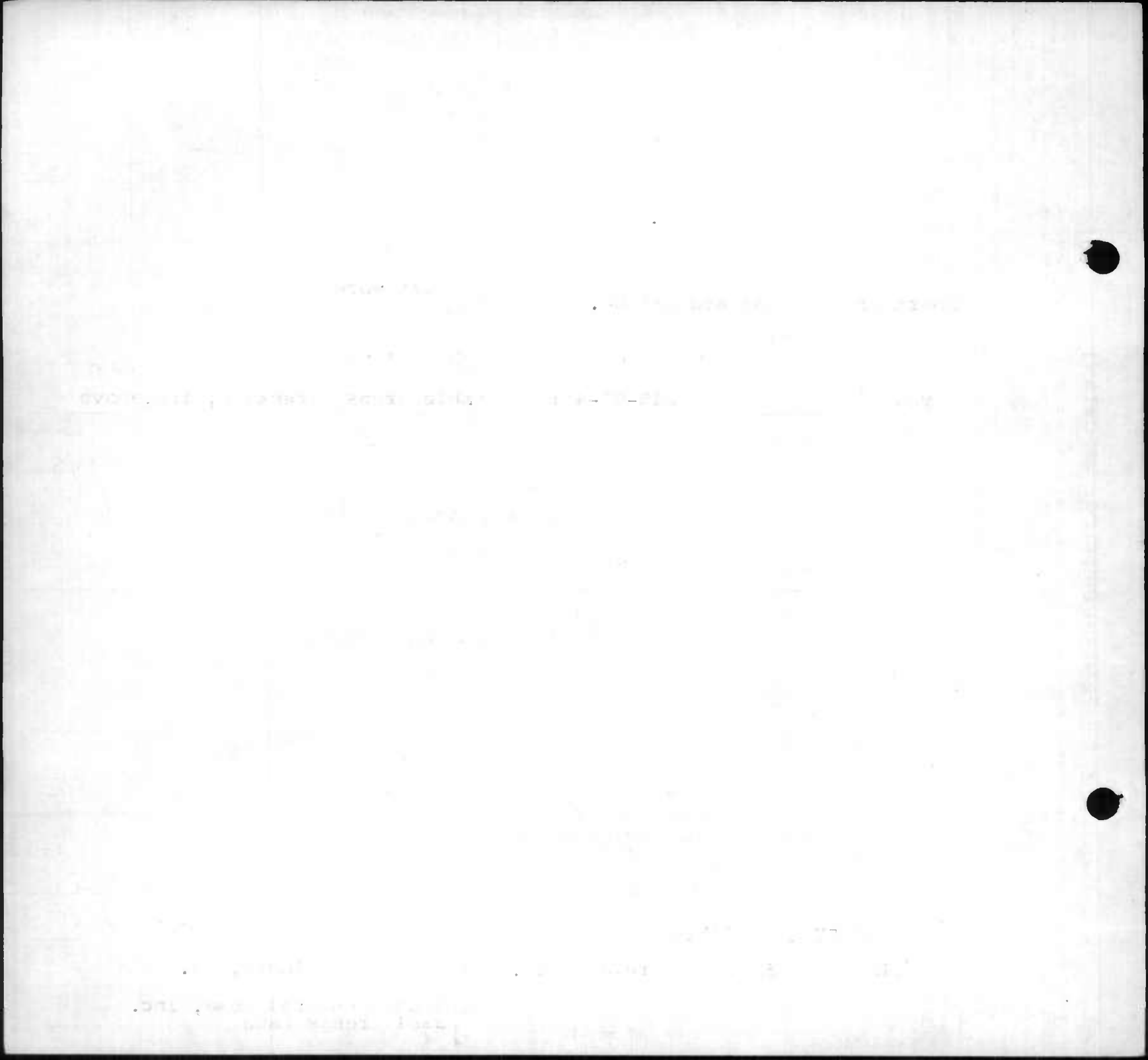




FUNERAL DIRECTOR: IMPORTANT

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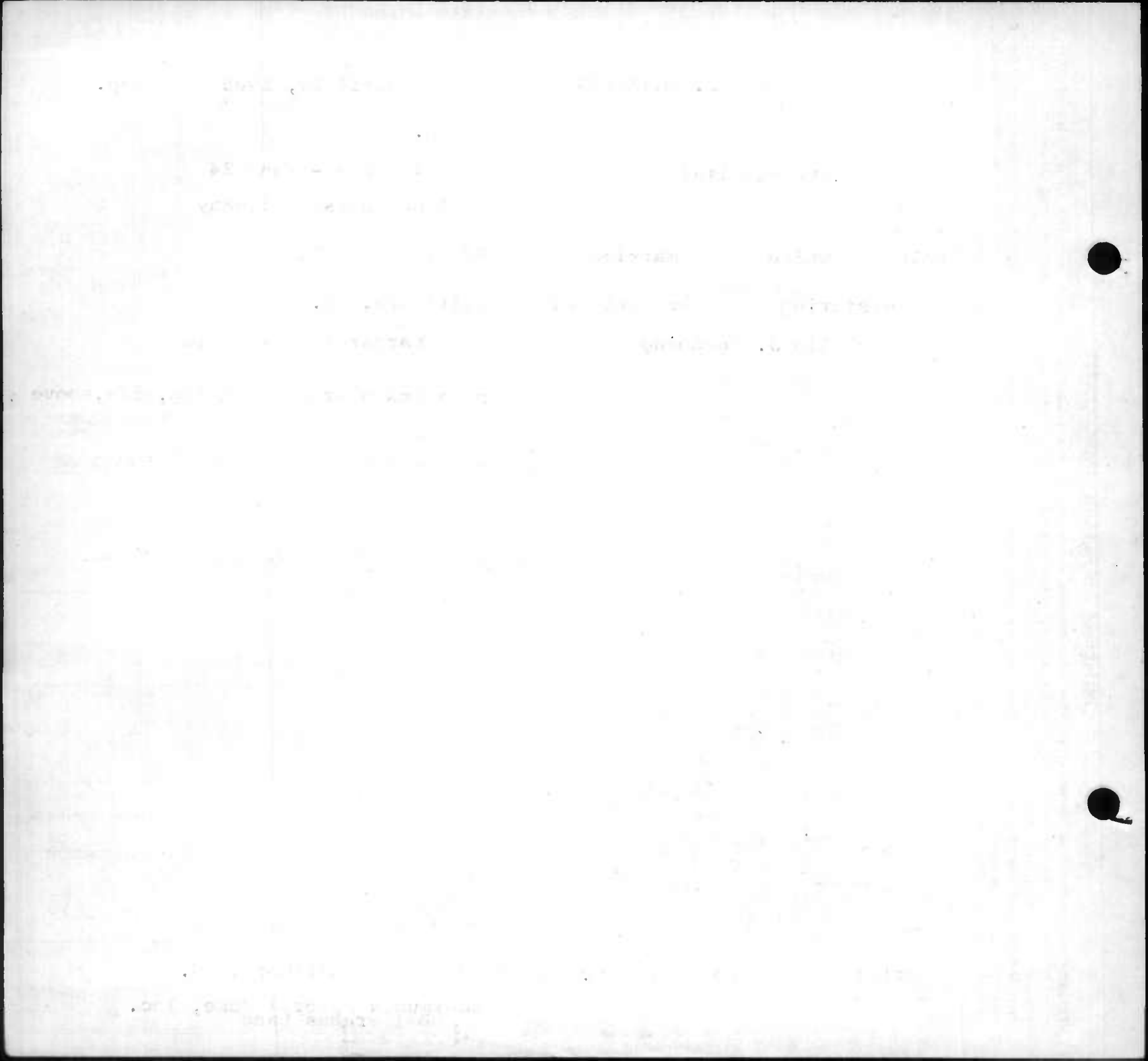
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 65 4753						
BIRTH NO. 65 4753		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) John Frederick Streckfus					2. DATE AND HOUR OF DEATH 5-2-65 11 30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 26-03 D. STREET ADDRESS (If rural, give location) 3520 Clifton Ave.						
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married			8. DATE OF BIRTH 2-5-97	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days		11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator			10B. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.			11. BIRTHPLACE (State or foreign country) Baltimore Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Streckfus					14. MOTHER'S MAIDEN NAME Barbara Fehr						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes			16. SOCIAL SECURITY NO. 215-07-4417			17. INFORMANT Mable Bruns Streckfus, wife, above					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Parkinson's Disease.					CAUSE OF DEATH (A) Cerebral Thrombosis DUE TO (B) Arteriosclerotic Cardiovascular disease. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 20 days.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-13-65 to 5-2-65, that (I) (we) last saw the deceased alive on 5-2-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Rodney L. Brimhall M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5-2-65			
23C. PHYSICIAN'S NAME (Type) RODNEY L. BRIMHALL					23D. ADDRESS M.D. Union Memorial Hospital						
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/65		24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Park			24D. LOCATION (City, town, or county) (State) Baltimore, Md.				
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1965			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3321 Brehms Lane					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 2em;">65 4754</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">65 4754</span>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>PHILIP J. BOENNING</b>			2. DATE AND HOUR OF DEATH <b>April 29, 1965 9 p.</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>City Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <span style="font-size: 2em;">26-44</span>		
5. SEX <b>male</b> 6. RACE <b>white</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>			8. DATE OF BIRTH <b>2/6/1891</b> 9. AGE (in years lost birthday) <b>74</b> 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholstering</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Philip J. Boenning</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Weismantle</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS <b>Anita Rosenberger Boenning, wife, above</b>					
18. <span style="font-size: 2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE CORONARY OCCLUSION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIOSCLEROSIS - General 2 years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 2em;">7/14/61</span> 19 to <span style="font-size: 2em;">4/28/65</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 2em;">4/28/65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Benj. B. Moses</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>5/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>BENJ. B. MOSES</b> M.D.				23D. ADDRESS <b>448 N. LUZERNE AVE BALTO. 24, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/3/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 4 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Fink</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 4755	
BIRTH NO. 65 4755				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Louis Duschel (DUSCHEL)</b>		2. DATE AND HOUR OF DEATH <b>5/1/65 7<sup>00</sup> A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>26-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 13</b> D. STREET ADDRESS (If rural, give location) <b>3301 Lammview Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/10/80</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mattress Maker-Balto Spring &amp; Bed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph Duschel</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>214-0137078</b>		17. INFORMANT <b>Robert E. Stoner</b> ADDRESS <b>University Hospital</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) <b>422.1 I</b> <b>Arteriosclerotic Cardiovascular Disease</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Cerebral Arteriosclerosis</b>		<b>Years</b>	
		(C) <b>Bronchopneumonia</b>		<b>Weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/30</b> 19 <b>65</b> to <b>5/1</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/1</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert E. Stoner, M.D.</b>				23B. DATE SIGNED <b>5/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert E. Stoner</b>				23D. ADDRESS <b>University Hospital Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/4/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D. BY HEALTH DEPT. <b>MAY 4 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Stoner</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>43331 Brehms Lane</b>	

1  
8

1944 - 1945  
1946 - 1947

- - -

1948 - 1949  
1950 - 1951

1952 - 1953  
1954 - 1955

LS: 43-16-70 1

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4756

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Estelle Schafling

2. DATE AND HOUR OF DEATH

April 30, 1965

10:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

521 N. Rose Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

5-23-82

9. AGE (In years  
last birthday)

82

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland, Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Merrick

14. MOTHER'S MAIDEN NAME

unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Uremia

2 Weeks

ANTECEDENT CAUSES

(B)

DUE TO

Pyelonephritis

?? Month

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Adenocarcinoma of Colon

6 Months

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 24 19 65 to April 30 19 65,  
that (I) (we) lost saw the deceased alive on April 30, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

April 30, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Charles Carpenter

M.O.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/4/65

24C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

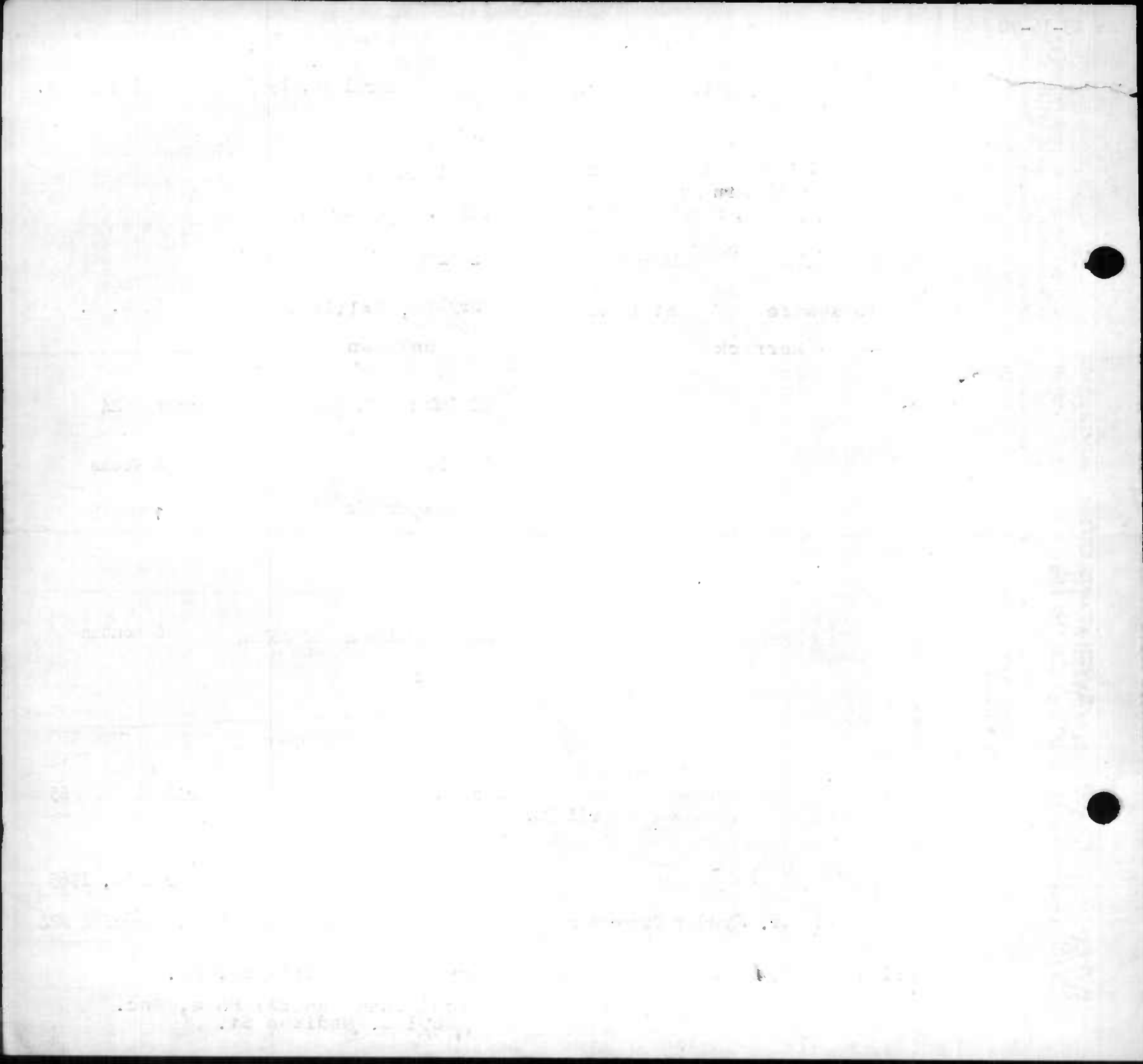
ADDRESS

42601 E. Madison St.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





BIRTH NO.

65 4757

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)M.  
BESSIE PRIDGEON

2. DATE AND HOUR PRONOUNCED DEAD

May 2, 1965

4:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2229 E. Madison St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

2-13-1903

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FOELLER

14. MOTHER'S MAIDEN NAME

MARGARET MULFINGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret A. Herbert - 2229 E. Madison St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Brätenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-5-65

23C. NAME of CEMETERY or CREMATORY

HOLY REDEEMER CEM.

23D. LOCATION

(City, town, or county)

BALTO., Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Hartley Miller - 2334 Jefferson St.

# VALLEY FOLIO

PRODUCTION

U.S.A.

S-520

BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
BIRTH NO. 65 4758				Registered No. 65 4758			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) WALTER ARTHUR SHANK				2. DATE AND HOUR PRONOUNCED DEAD May 2, 1965 3:00 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) City Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 7101 E. Biddle St.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 8-23-1930	9. AGE (In years last birthday) 34	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY AUTO INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER J. SHANK				14. MOTHER'S MAIDEN NAME GEORGIANNA McCLELLAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Elizabeth R. Shank - 7101 E. Biddle St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple traumatic injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) South of Lombard on Ponca St.			
21D. TIME OF INJURY (APPROX.) 5 2 65 2:40a		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Driver of motorcycle in fixed-object accident.			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker DATE SIGNED 5-2-65							
23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23B. DATE 5-6-65		23C. NAME OF CEMETERY or CREMATORY CEDAR HILL CEM.		23D. LOCATION (City, town, or county) (State) BALTO., Md.	
24A. DATE REC'D BY HEALTH DEPT. MAY 5 1965		24B. NAME OF REGISTRAR Robert E. Fisher, M.D.		24C. FUNERAL DIRECTOR ADDRESS Hartley Miller - 2334 Jefferson St.			

WALLER FORD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>65 4759</b>	
BIRTH NO. <b>65 4759</b>				1. NAME OF DECEASED <b>NINA MAY BRUNNER</b>		2. DATE AND HOUR OF DEATH <b>5 3 65 1:35 P M.</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27</b>			
				D. STREET ADDRESS (If rural, give location) <b>1305 BIRCH AVENUE</b>		<b>53-00</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>MARRIED</b>	8. DATE OF BIRTH <b>10 26 94</b>	9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE MCGRATH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 22 1435</b>		17. INFORMANT ADDRESS <b>ST AGNES HOSP RECORDS</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>AC. MYOCARDIAL INFARCTION</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASHD = CHF.</b>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>							
21A. DATE OF OPERATION <b>5 2 1965</b>		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22A. AUTOPSY? (Yes or No)		22B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5 2 1965</b> to <b>5 3 1965</b> , that (I) (we) last saw the deceased alive on <b>5 3 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. J. RODRIGUEZ</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. J. RODRIGUEZ</b>				23D. ADDRESS <b>St Agnes Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery, Baltimore, Maryland</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Griffin &amp; Son 1327 Sulphur Sp. Rd</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4760		CITY HEALTH DEPARTMENT		Registered No. 65 4760	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Owen Joseph SAMSEL		2. DATE AND HOUR OF DEATH MAY 2, 1965 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where dec. lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		D. STREET ADDRESS (If rural, give location) 1301 W - 42nd St			
5. SEX Male	6. RACE Caucasian	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 12-27-83	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired chauffeur Coal & Wood
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W. Samsel	
14. MOTHER'S MAIDEN NAME Elizabeth Riley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-3451	
17. INFORMANT Chart		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia, left and pulmonary edema		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive heart failure ARB					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION April 30, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED L-inguinal hernia		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from April 29 1965 to May 2 1965, that (we) last saw the deceased alive on May 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ellen Ann Dagon Millan		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 2 1965	
23C. PHYSICIAN'S NAME (Type) Ellen Ann Dagon Millan, M.D.		23D. ADDRESS Union Memorial Hospital Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6 May 65		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
24D. LOCATION Baltimore Co. Maryland		24E. FUNERAL DIRECTOR Burgee Funeral Home 3631 Falls Rd		24F. ADDRESS Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. NAME OF REGISTRAR Burgee Funeral Home	

5

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

3. The third part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

4. The fourth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

5. The fifth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

6. The sixth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

7. The seventh part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

8. The eighth part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.



BIRTH NO.

65

4761

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

4761

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LAWRENCE CARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

May 1, 1965

11:17 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1627 Lamot Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

Nov. 24/41

9. AGE (In years  
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

DAVID CARRINGTON

14. MOTHER'S MAIDEN NAME

VERSIE DOCCATT

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give year or dates of service)

YES

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gun shot wound of chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

N. E. Corner of Aisquith &amp; Federal Sts.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 1 65 11:00p

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-1-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-5-65

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

(State)

A. A. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

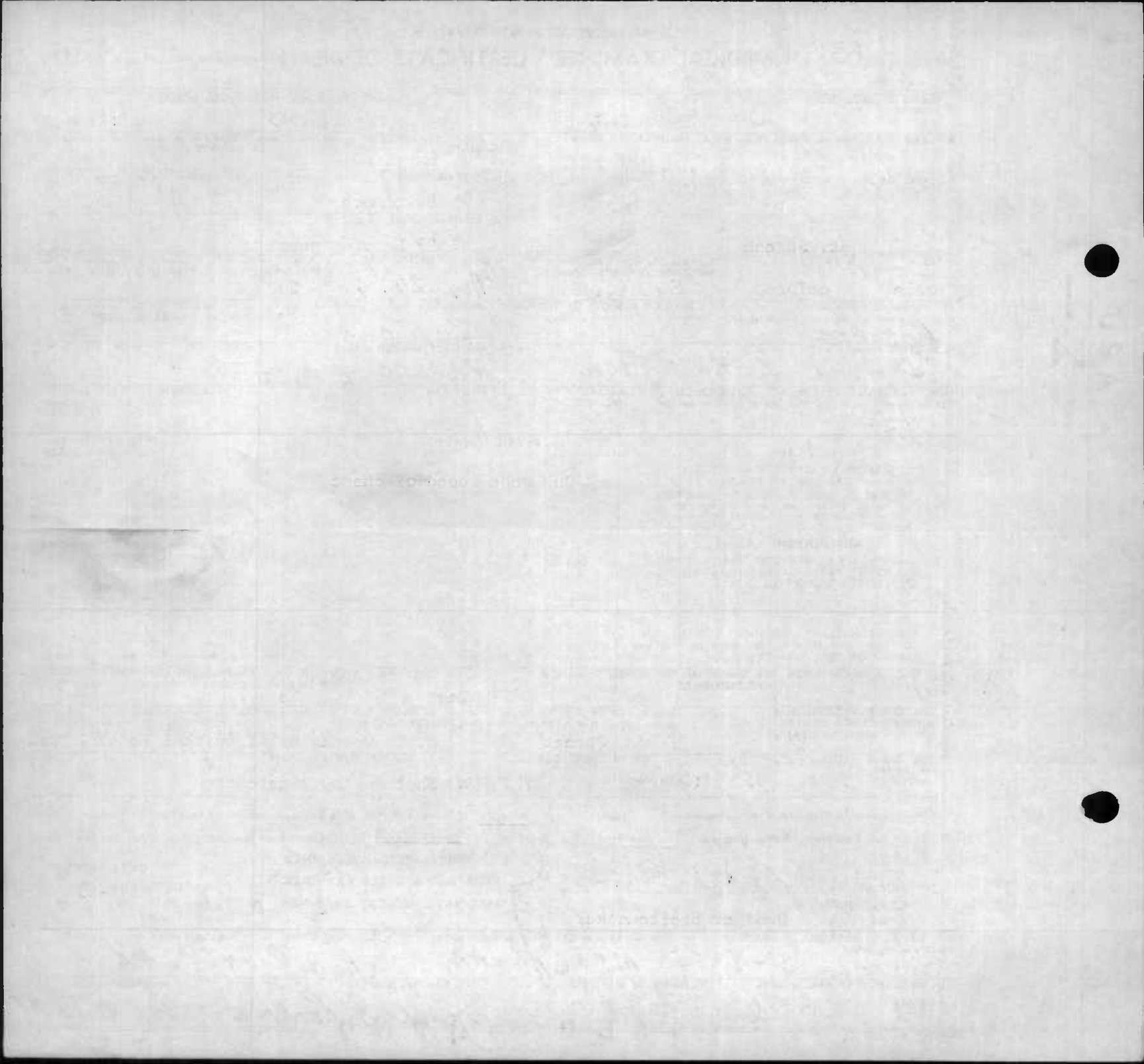
24B. NAME OF REGISTRAR

Robert E. Fawcett, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

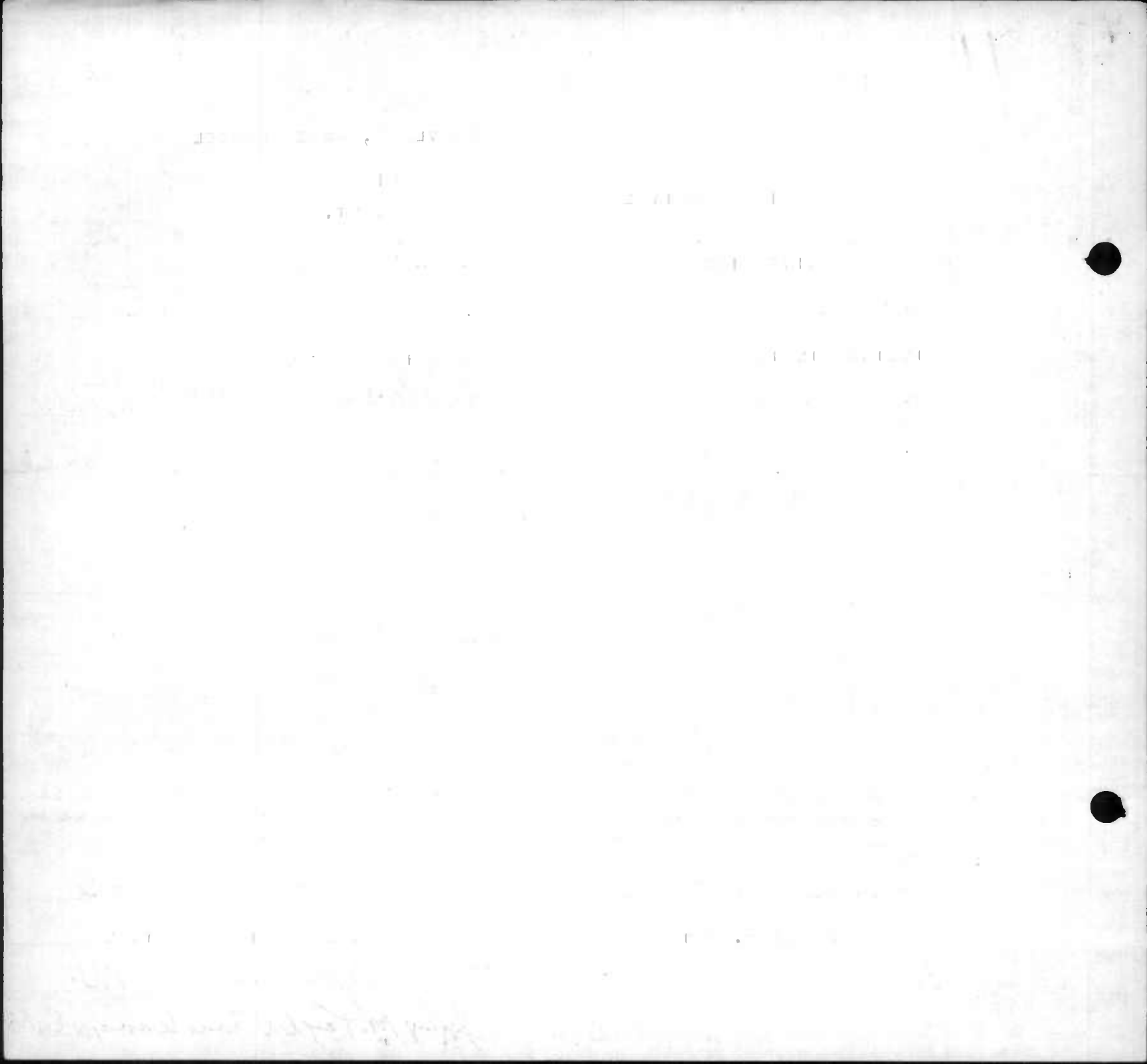
Joseph J. Locks, Jr. 13041 Central Ave



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

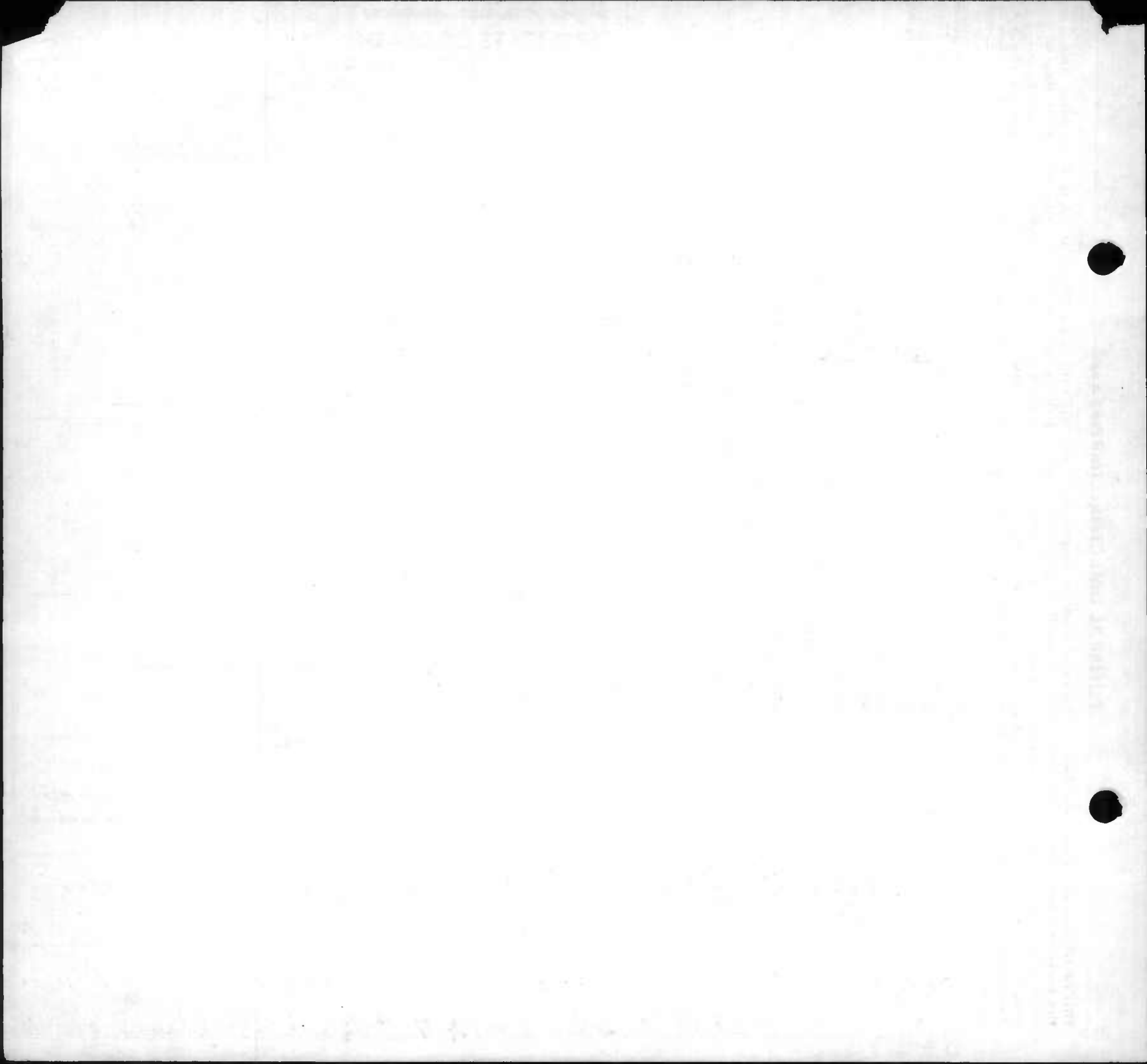
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4762					REGISTERED NO. 65 4762				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>Williams, Clarence E.</b>					2. DATE AND HOUR OF DEATH <b>5-2-65 10 12 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND, ANNE ARUNDEL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ANNAPOLIS</b> D. STREET ADDRESS (If rural, give location) <b>815 WEST ST.</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>3-22-88</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>A.A. Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>WILLIAM WILLIAMS</b>					14. MOTHER'S MAIDEN NAME <b>JESSIE HASSELL</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Fred Stehle</b>			ADDRESS <b>143 Spa Drive Annapolis, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Probable myocardial infarction 10 minutes</b> <b>ASCVD</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Congestive heart failure</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4.30</b> 19 <b>65</b> to <b>5-2</b> 19 <b>65</b> , that (I) <b>(u)</b> last saw the deceased alive on <b>5.2.65</b> 19 <b>65</b> and that in (my) <b>(u)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(u)</b> (did) <b>(u)</b> view the body after death.									
23A. SIGNATURE <b>James F. Fries</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>5.2.65</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES F. FRIES</b>					23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Joseph M. Taylor</b>			ADDRESS <b>Son Annapolis Md.</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

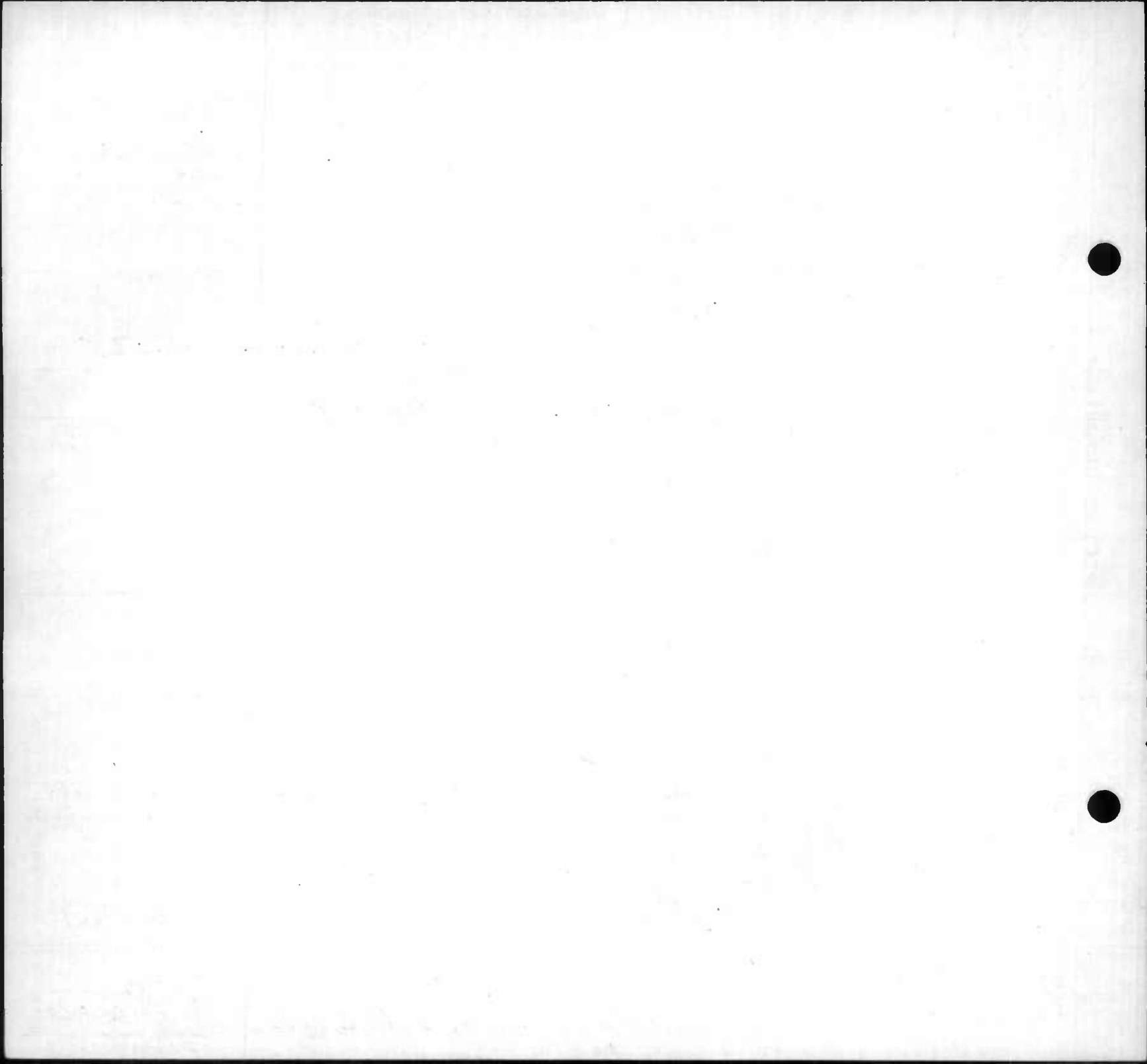
BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED No.	
BIRTH NO.		65 4763		65 4763	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH H. VALK</b>				2. DATE AND HOUR OF DEATH <b>5/2/65 7:35 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>ANNA POLIS 5210</b> D. STREET ADDRESS (If rural, give location) <b>225 GLOUCESTER ST.</b>	
5. SEX <b>F</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>7/16/77</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>DEANIS CLAUDE HANDY</b>			14. MOTHER'S MAIDEN NAME <b>ANNA BAGWELL</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT ADDRESS <b>ANNA DOUGLAS HANDY #2</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>CARCINOMA SIGMOID COLON</b> (B) <b>—</b> (C) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4/14/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 10 1965</b> to <b>MAY 2 1965</b> , that (I) (we) last saw the deceased alive on <b>MAY 2 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Martin E. Zips</b> M.D.				23B. DATE SIGNED <b>MAY 2, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>—</b>		23D. ADDRESS <b>—</b> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-5-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ST ANNE'S</b>	
24D. LOCATION (City, town, or county) (State) <b>ANNAPOLIS MD.</b>		24E. FUNERAL DIRECTOR ADDRESS <b>John M. Zips &amp; Sons Annapolis, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Falcato</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4764	
BIRTH NO. 65 4764		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KOENIG, FREDERICK WM.			
2. DATE AND HOUR OF DEATH		J. 2. 65 8:20 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD B. COUNTY BALTIMORE 28-04			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE 21229			
D. STREET ADDRESS (If rural, give location)		5414 Frederick Ave			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 6.6.15	9. AGE (In years last birthday) 49	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10B. KIND OF BUSINESS OR INDUSTRY Managerial/Battery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edw. Henry Koenig		14. MOTHER'S MAIDEN NAME Dorothy Gold VOLZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WWII		16. SOCIAL SECURITY NO. 216 05 3045		17. INFORMANT HOSP. REC. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Cirrhosis of liver		4.30.65	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Esophageal bleeding		5.2.65	
		(C) DUE TO above			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 5.1.65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal bleeding		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White A1 <input type="checkbox"/> Not White A1 Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4.30 19 65 to 5-2 19 65, that (I) (we) last saw the deceased alive on 5-2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Frank J. Rueda M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5.2.65	
23C. PHYSICIAN'S NAME (Type) FRANK J. RUEDA M.D.		23D. ADDRESS Franklin Square Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/5/65		24C. NAME of CEMETERY or CREMATORY BALTO. NATIONAL	
24D. LOCATION BALTO. 29 MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965			
25B. NAME OF REGISTRAR Robert E. Fink		25C. FUNERAL DIRECTOR ADDRESS EAST MAR. LAB 301 FREDERICK 21229			

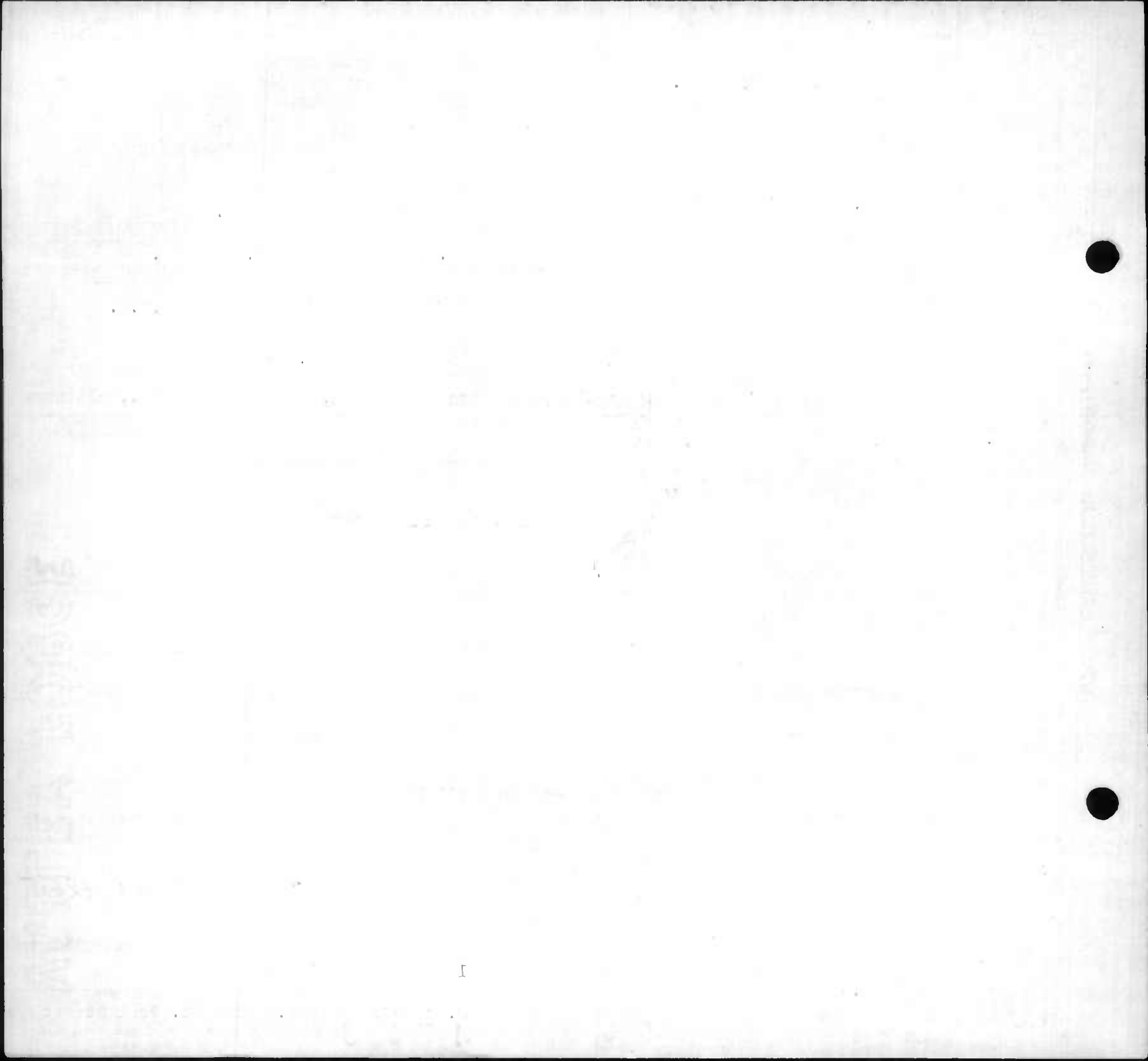




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

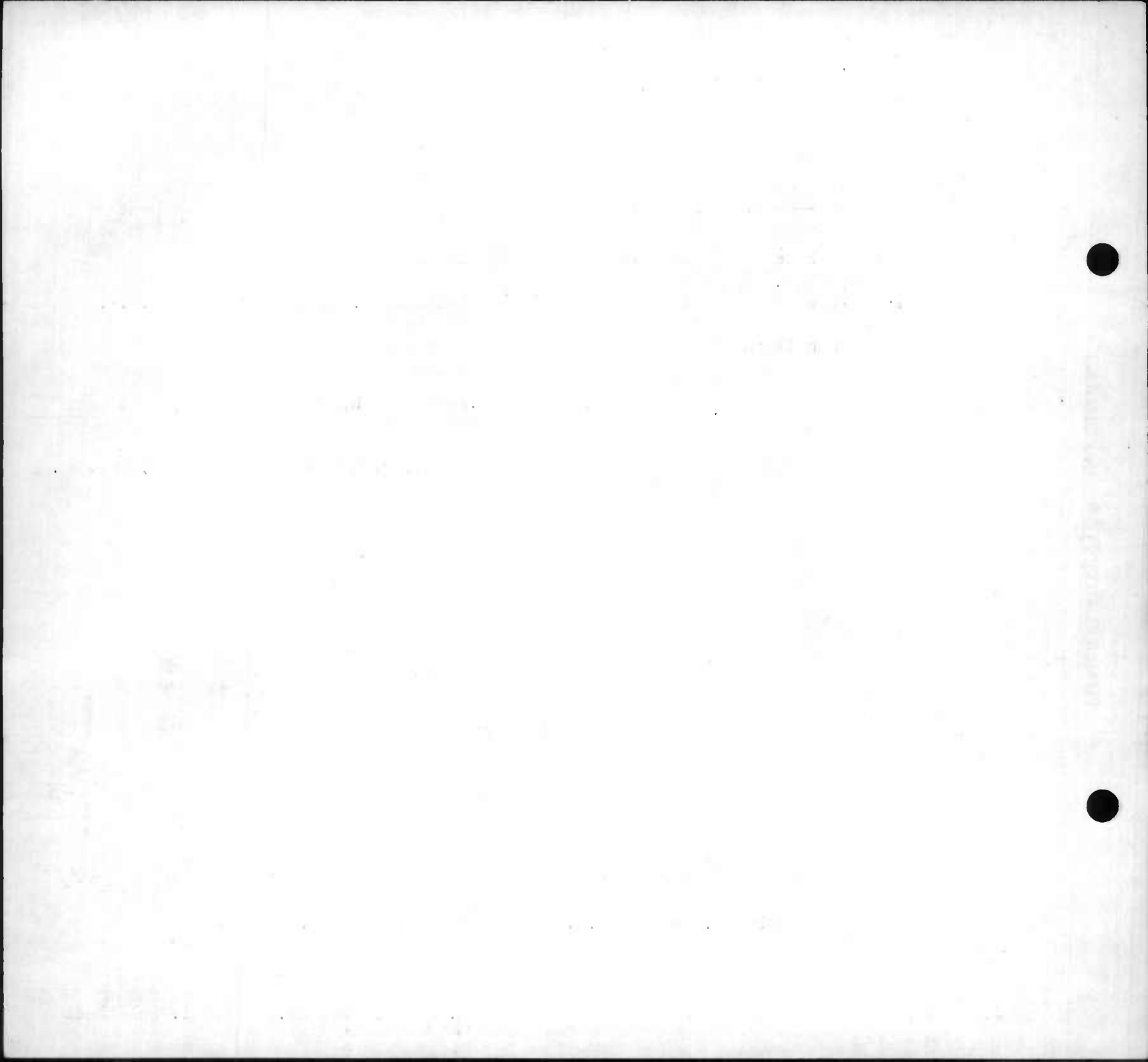
BIRTH NO. 65 4765		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4765	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Bowen, Jefferson M.			2. DATE AND HOUR OF DEATH April 29 1965 9 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  St. Joseph's Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 10-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1003 Brentwood Ave. Zone 02		
5. SEX M	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 6, 1888	9. AGE (In years last birthday) 76 yrs.	If Under 1 Yr. Months Days 7 mos.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Disabled War Veteran			11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Mary Ella (Unknown)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I			16. SOCIAL SECURITY NO. 210-03-7891		
17. INFORMANT ADDRESS Miss Ruth Green, 3654 Lyndale Ave., Baltimore					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) Malnutrition & Dehydration DUE TO (B) Atherosclerosis DUE TO (C)		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from On April 29 19 65 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jimmy P. Corder			23B. DATE SIGNED May 1 1965		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-3-65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) Baltimore, Md		24E. DATE REC'D BY HEALTH DEPT. MAY 5 1965		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc., 1217 St. Paul Street		24H. ADDRESS		24I. DATE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		65 4766		65 4766	
BIRTH NO.		M.E. CASE NO.		Registered No.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
ELIZABETH F. MARTINO			May 1, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Mount Convalescent Road 3706 Nortonia Road Baltimore, Maryland 21216			A. STATE Maryland B. COUNTY Baltimore 21216		
5. SEX female			6. RACE white		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed			8. DATE OF BIRTH April 1, 1897		
9. AGE (In years last birthday) 68			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		
11. BIRTHPLACE (State or foreign country) Louisville, Kentucky			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Allen			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		
17. INFORMANT Mr. Robert Koch, 3913 Ednor Road, Baltimore			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 3 years		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21. DATE OF OPERATION			22. CONDITION FOR WHICH OPERATION WAS PERFORMED		
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
25. TIME OF INJURY (Month) (Day) (Year) (Hour)			26. INJURY OCCURRED		
27. HOW DID INJURY OCCUR?			28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
29. I certify that (I) (this hospital) attended the deceased from May 1, 1965 to May 1, 1965, that (I) (we) last saw the deceased alive on April 30, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
30. SIGNATURE Abraham B. Hurwitz, M.D.			31. DATE SIGNED May 3, 1965		
32. PHYSICIAN'S NAME (Type)			33. ADDRESS		
Abraham B. Hurwitz, M.D.			3403 Garrison Blvd., Baltimore, Md		
34. BURIAL CREMATION, REMOVAL (Specify)			35. DATE		
BURIAL			5-5-65		
36. NAME OF CEMETERY or CREMATORY			37. LOCATION (City, town, or county) (State)		
Baltimore Nationak Cemetery			Baltimore		
38. DATE REC'D BY HEALTH DEPT.			39. NAME OF REGISTRAR		
MAY 5 1965			Robert E. Farkes		
40. FUNERAL DIRECTOR			ADDRESS		
Wm. Cook-Brooks, Inc., 1217 St. Paul Street					



BIRTH NO.

65

4767

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

4767

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PERCY WINGFIELD

2. DATE AND HOUR PRONOUNCED DEAD

5-2-65

10:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. JOSEPH'S HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5014 The Alameda 21212

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

4/25/98

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Restaurant OWNER

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

J.R.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Nell Wingfield

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

415-05-7501

17. INFORMANT

ADDRESS

HELETA WINGFIELD 5014 THE ALAMEDA

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/6/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. J. Glatman, Jr. 1701 McCulloch St.

Balto. Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4768				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4768	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>TRUDA BELL CROUSE</b>				2. DATE AND HOUR OF DEATH <b>5/2/65</b> <b>7<sup>25</sup> P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>21-02</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>332 S. POPPLETON ST.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>11/17/14</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife at Home</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>W. VA.</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>NOAH MCCOY</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN HAMMOND</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>✓</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mr. Daniel Crouse</b>	
				ADDRESS <b>above address</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. <b>170X I</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) <b>CARCINOMA OF BREAST &amp; METASTASES</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) <b>BREAST &amp; METASTASES</b>			
				(C) <b>—</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <b>Yes</b> or <b>No</b> <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 27 1965</b> to <b>May 2 1965</b> , that (I) (we) last saw the deceased alive on <b>May 2 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Martin E. Zipser</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Martin E. Zipser M.D.</b>				23D. ADDRESS <b>22 S. Greene St Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mc Coy Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Webster Springs W. Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fadden</b>		25C. FUNERAL DIRECTOR <b>John F. Brown</b>			
				ADDRESS <b>95 Hollis Balto. 23, Md.</b>			

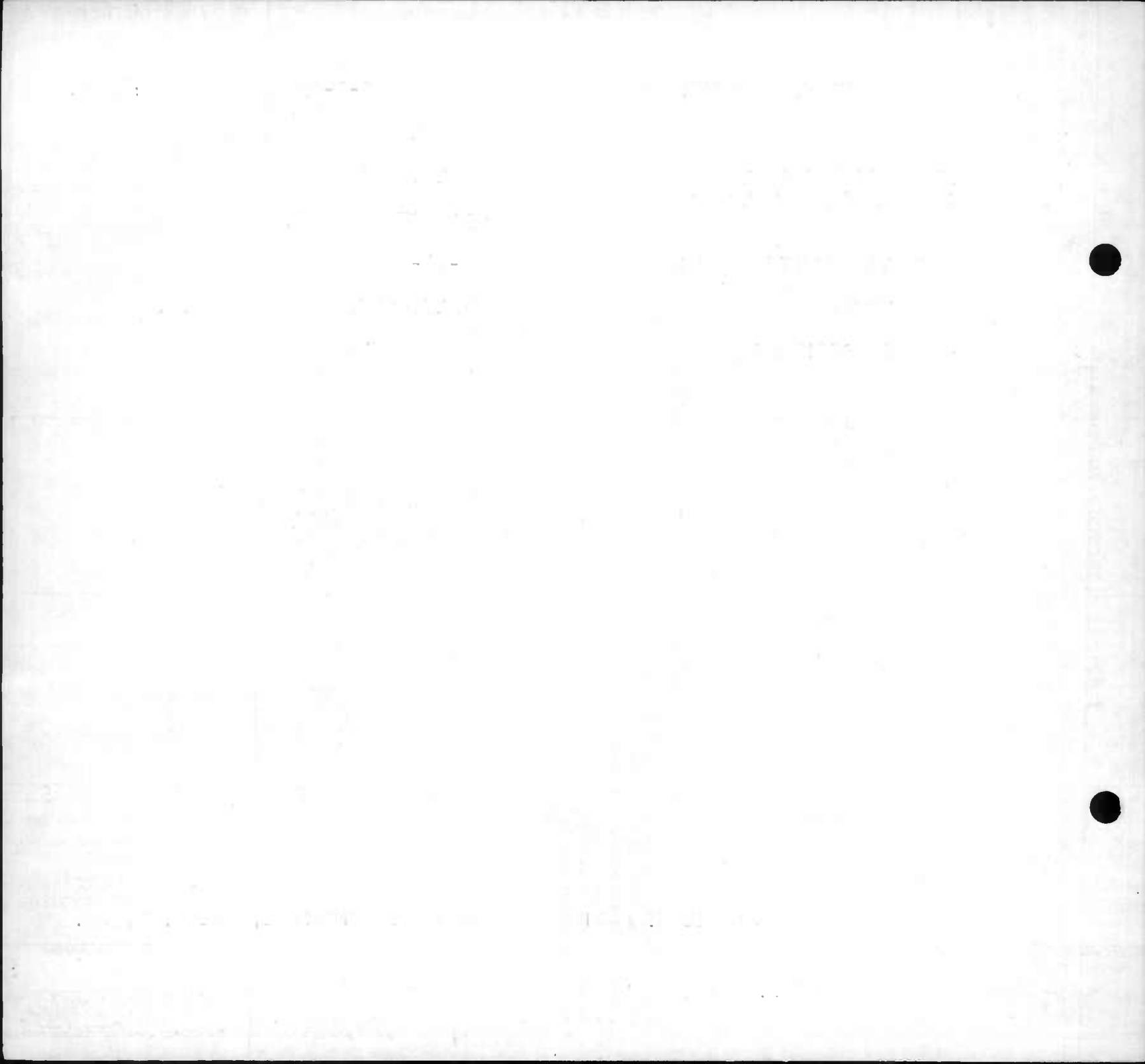
and



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

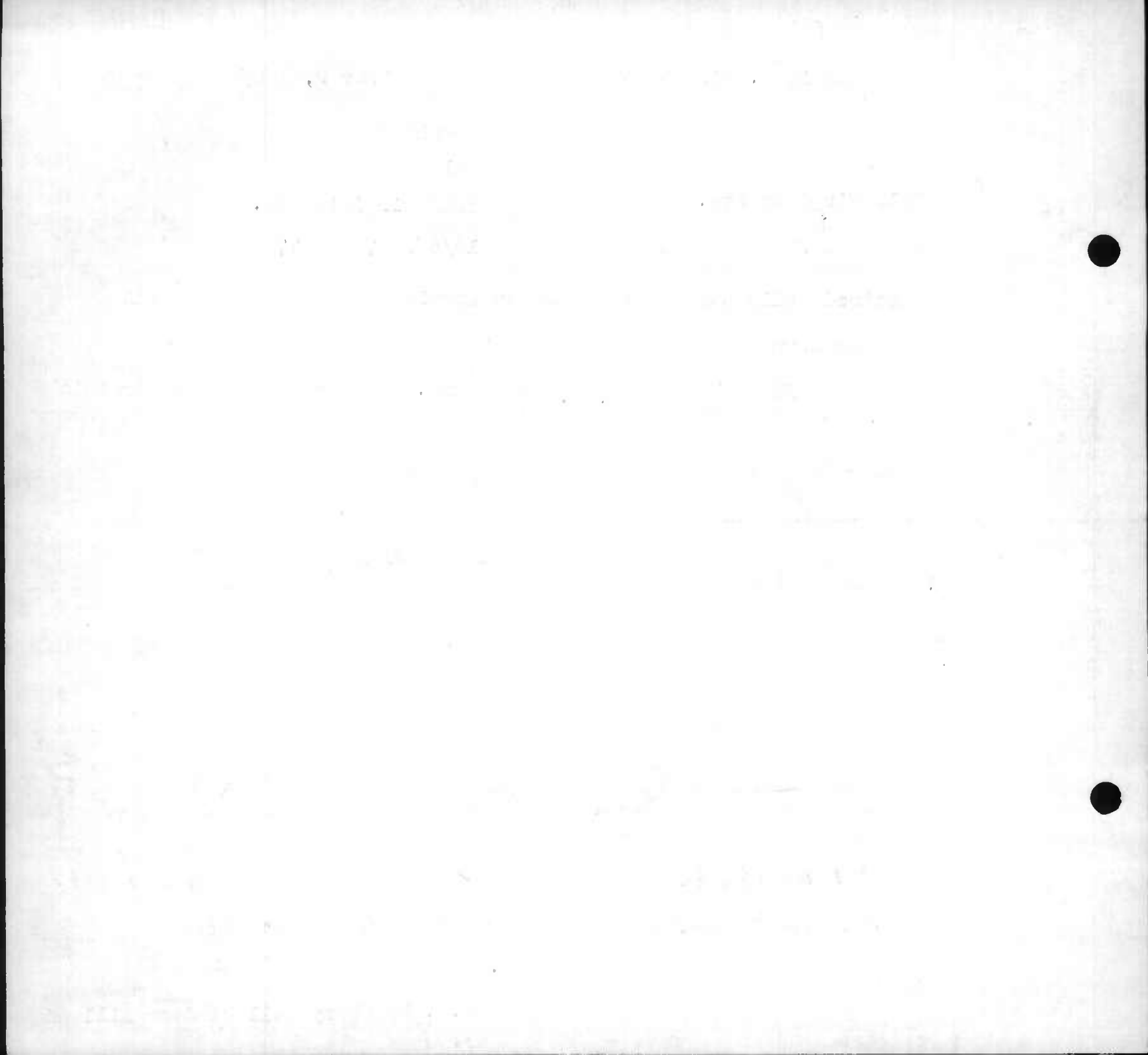
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4769</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4769</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ETHEL MARY WEINBERG</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5-3-65</span>   <span style="font-size: 1.2em;">6:45 A.</span> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">ST AGNES HOSPITAL CATON AVE AND WILKENS</span>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">20-04</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">339 STINSON ST.</span>		
5. SEX <span style="font-size: 1.2em;">FEMALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">WIDOWED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">2-14-00</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">65</span>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HSWF</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">at home</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MD</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">ADAM STEINBACH</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ELIZABETH BURKARD</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">-</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">-</span>		17. INFORMANT <span style="font-size: 1.2em;">Mr Henry Weinberg</span> ADDRESS <span style="font-size: 1.2em;">521 Parkside Ave</span>	
18. <span style="font-size: 1.2em;">260X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 1.2em;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Acute myocardial Infarction</span> DUE TO <span style="font-size: 1.2em;">Coronary atherosclerosis</span> (B) <span style="font-size: 1.2em;">Diabetes mellitus</span> DUE TO <span style="font-size: 1.2em;">Nephropathy - Chronic</span> (C) _____  INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAY 1</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">MAY 3</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 3</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Rafael H. Marin</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/3/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RAFAEL H. MARIN</span>			23D. ADDRESS <span style="font-size: 1.2em;">ST AGNES HOSPITAL, BALTO. 29, MD.</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5/6/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Emmanuel Church Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Laurel, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 5 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John J. Cowan &amp; Son Inc.</span>		ADDRESS <span style="font-size: 1.2em;">901 Hollins St. 23, Md.</span>			



# FUNERAL DIRECTOR: IMPORTANT

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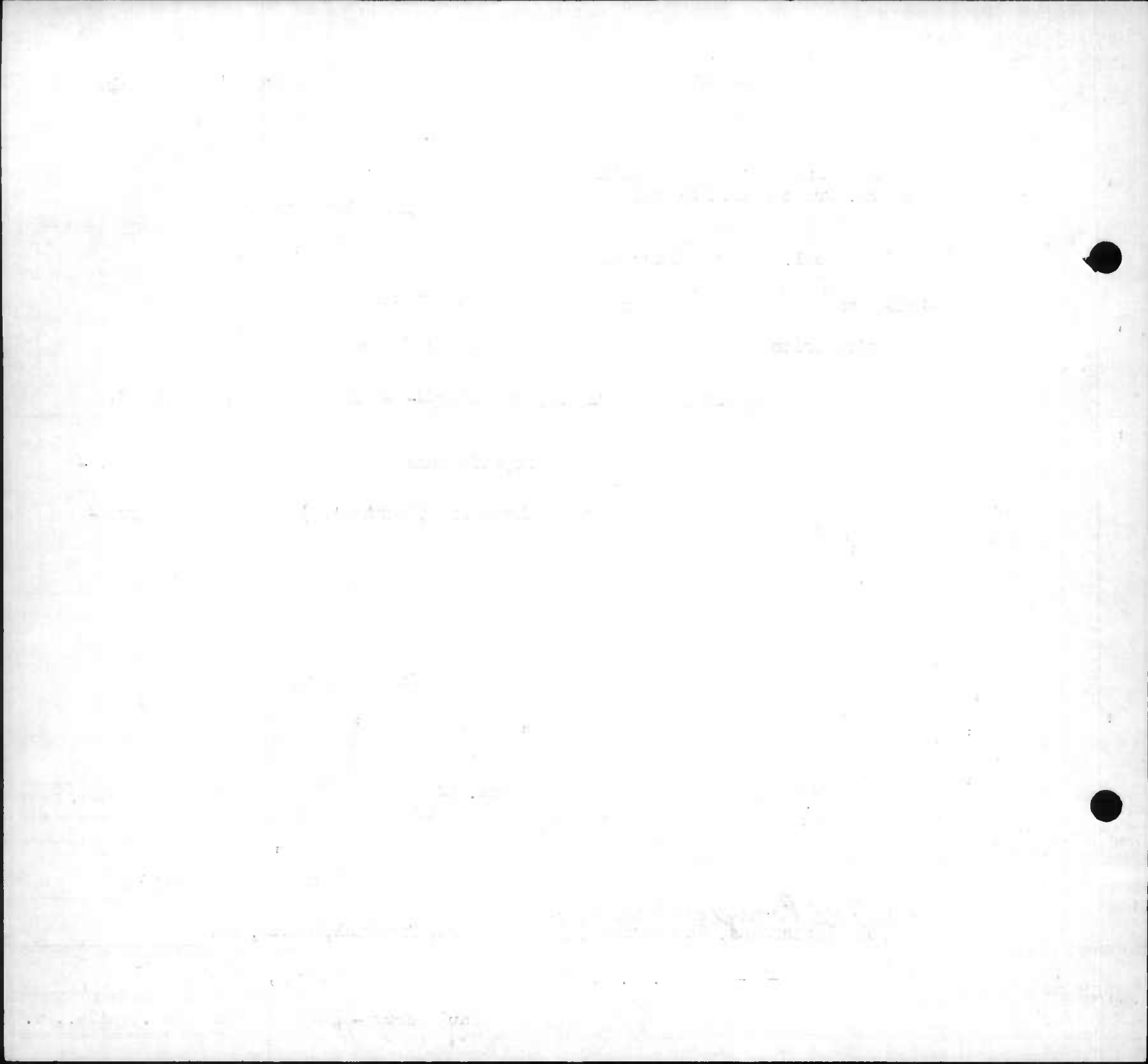
BIRTH NO. <span style="font-size: 1.5em;">65 4770</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 1.5em;">65 4770</span>	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Louis D. Eisenhart</b>			May 2, 1965 <span style="float: right;">3:40 P.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>3018 Virginia Ave.</b>			A. STATE <b>Maryland</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3018 Virginia Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>12/6/1887</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Milk Man</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Royal Donlogon</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Unknown</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215.10.2345</b>			17. INFORMANT <b>Mrs. Dorothy Frock</b>		
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>Cardio Vascular Dis</b> DUE TO (C) <b>Vascular Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 hrs</b> <b>Jan 9 1960</b> <b>Jan 9 1960</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan 9 1960</b> to <b>May 2 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>May 1 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>F. L. DE BARBIERI</b>				23B. DATE SIGNED <b>May 3 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>F. L. DE BARBIERI</b>				23D. ADDRESS <b>4723 Park Height Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>MAY 5 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J.T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd</b>	



# FUNERAL DIRECTOR: IMPORTANT

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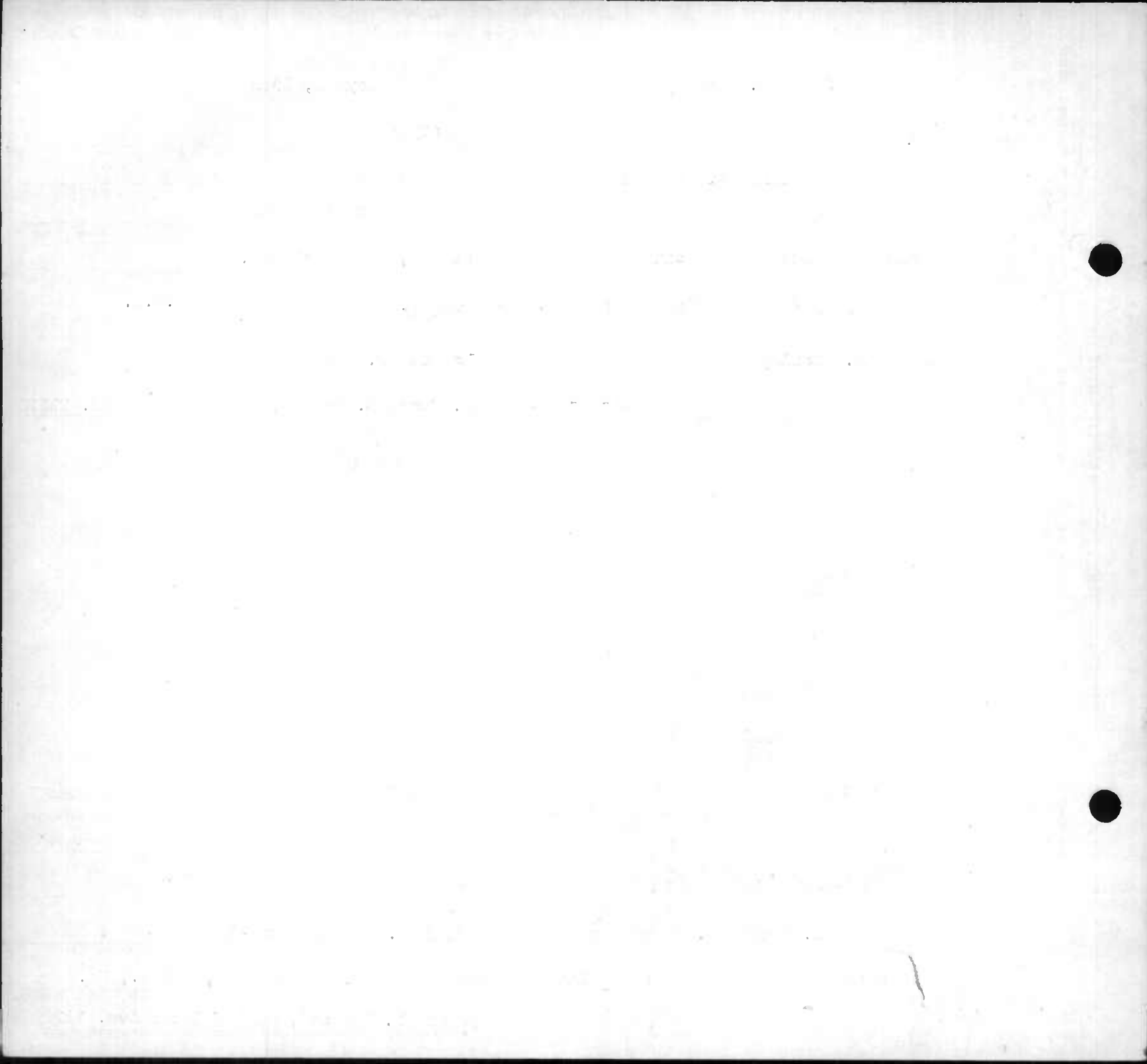
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 4771					CERTIFICATE OF DEATH					Registered No. 65 4771				
1. NAME OF DECEASED (Type or Print) <b>Joseph Brito</b>					2. DATE AND HOUR OF DEATH <b>May 3 '65</b>   <b>6:17</b> P. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Pa.</b> B. COUNTY <b>V-35</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Philadelphia</b> D. STREET ADDRESS (If rural, give location) <b>6042 Master Street</b>									
5. SEX <b>M</b>		6. RACE <b>col.</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>1/29/87</b>		9. AGE (In years lost birthday) <b>68</b>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Galleyman</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Seafaring</b>					11. BIRTHPLACE (State or foreign country) <b>Portugal</b>				
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					13. FATHER'S NAME <b>Pedro Brito</b>					14. MOTHER'S MAIDEN NAME <b>Maria Lomba</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes USA 1918-1919</b>					16. SOCIAL SECURITY NO. <b>024-07-2163</b>					17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Hepatic coma</b> DUE TO (B) <b>Cirrhosis (Laennec's)</b> DUE TO (C) _____										INTERVAL BETWEEN ONSET AND DEATH <b>2 wks. +</b> <b>4 yrs +</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>No</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 24</b> 19 <b>65</b> to <b>May 3</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>May 3</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE  <b>Nijole Brazauskas</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>										23B. DATE SIGNED <b>5/4/65</b>				
23C. PHYSICIAN'S NAME <b>Nijole Brazauskas, SA Surgeon (R)</b> M.D.										23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>5-10-65</b>					24C. NAME OF CEMETERY OR CREMATORY <b>U. S. National</b>				
24D. LOCATION (City, town, or county) (State) <b>Beverly, New Jersey</b>					25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				
25C. FUNERAL DIRECTOR <b>Paul Terry</b>					ADDRESS <b>4203 Haverford Ave., Phila., Pa.</b>									



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																													
BIRTH NO. 65 4772					CERTIFICATE OF DEATH					Registered No. 65 4772																			
1. NAME OF DECEASED (Type or Print) John L. Bailey					2. DATE AND HOUR OF DEATH May 1, 1965					M.																			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02																								
FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 1136 Sargeant Street					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 1136 Sargeant Street																			
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH March 2, 1883		9. AGE (In years last birthday) 82 Yrs.		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed					10B. KIND OF BUSINESS OR INDUSTRY Diamond Cabs Co.					11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.														
13. FATHER'S NAME John A. Bailey					14. MOTHER'S MAIDEN NAME Rachel F. Sipes					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 212-14-2135		17. INFORMANT ADDRESS Mrs. Grace L. Bailey, 1136 Sargeant St. 21223												
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <i>one year</i>														
										(B) _____ DUE TO					(C) _____ DUE TO														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
										21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?																			
22. I certify that (I) (this hospital) attended the deceased from <i>May 1960</i> 19 to <i>May 1</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>April 30</i> , 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															23A. SIGNATURE <i>Morris B. Schrieber</i> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <i>5-3-65</i>				
23C. PHYSICIAN'S NAME (Type) Dr. Morris B. Schrieber										23D. ADDRESS 1519 W. Lombard Street																			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 5/4/65					24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery					24D. LOCATION (City, town, or county) (State) Wilkins Avenue, Balto., Md.														
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965					25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>					25C. FUNERAL DIRECTOR Howard H. Hubbard					ADDRESS 4107 Wilkins Ave. 21229														

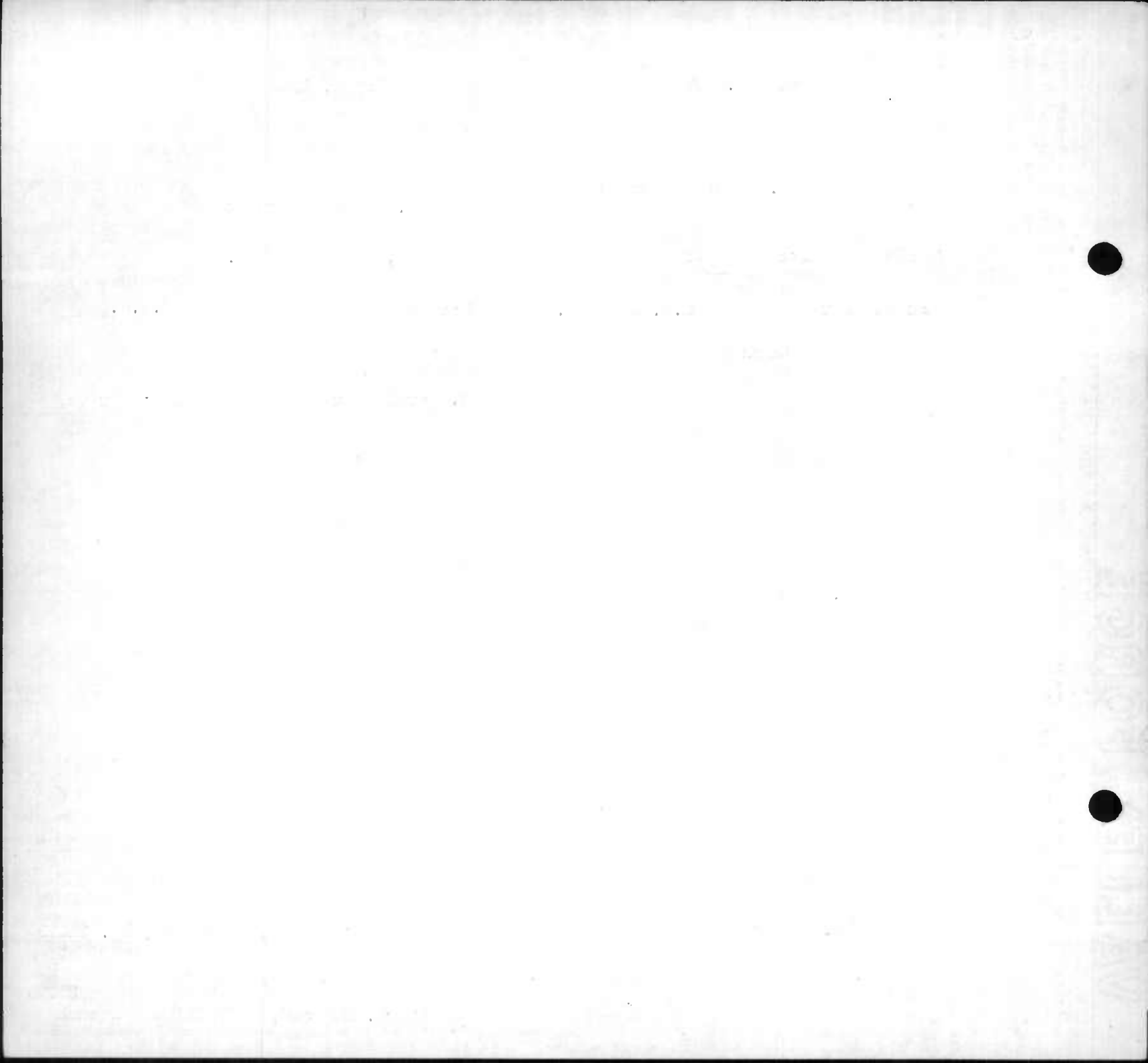




FUNERAL DIRECTOR: IMPORTANT

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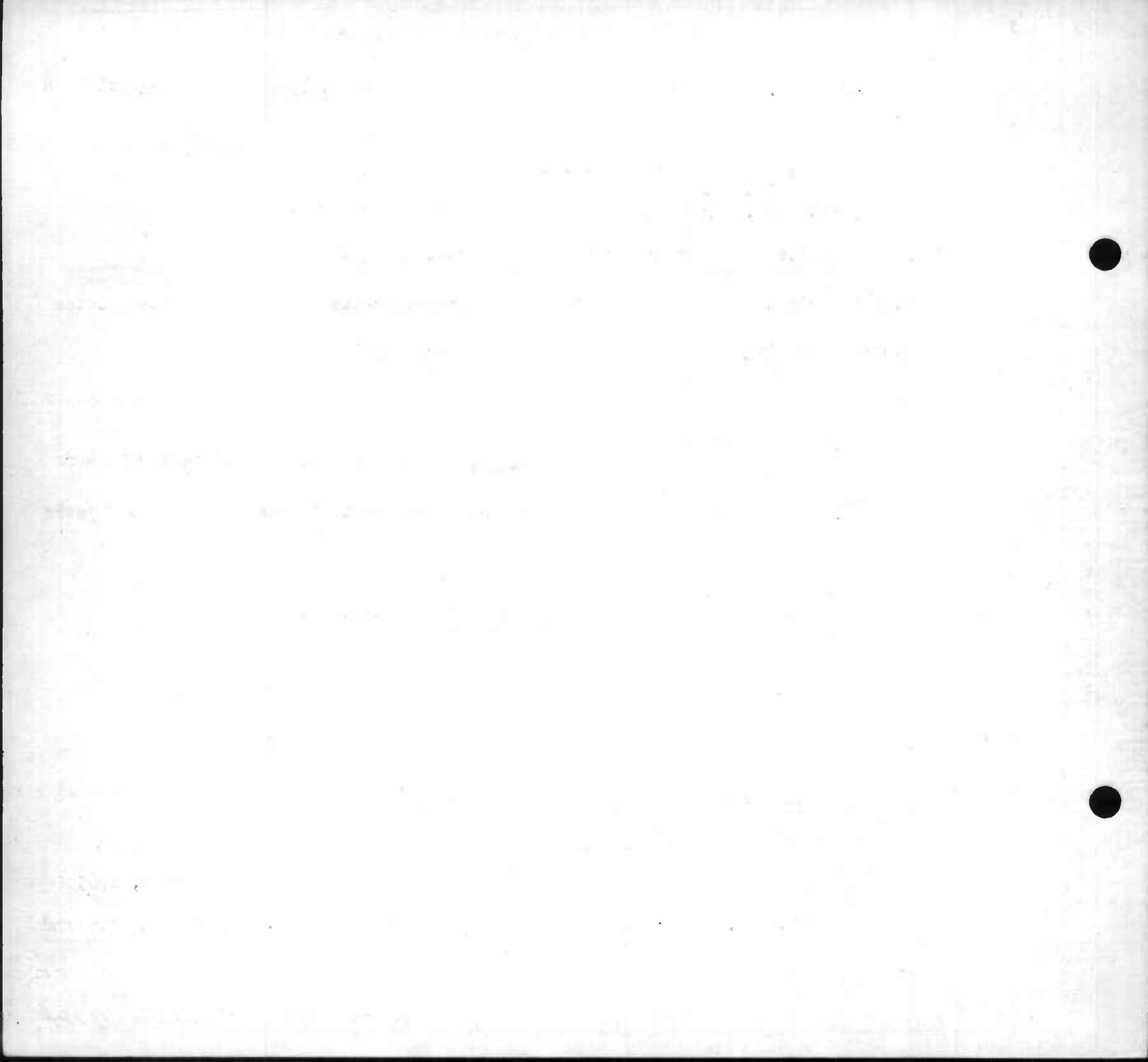
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <span style="font-size: 1.2em;">65 4773</span>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <span style="font-size: 1.2em;">65 4773</span></span> <span>M.E. CASE NO.</span> </div>											
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Mildred C. Freedy</span>						2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">May 1, 1965</span> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">446 S. Bentalou Street</span>						A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">20-05</span>					
5. SEX <span style="font-size: 1.1em;">Female</span>						6. RACE <span style="font-size: 1.1em;">White</span>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">Widowed</span>		8. DATE OF BIRTH <span style="font-size: 1.1em;">March 23, 1899</span>	
9. AGE (In years last birthday) <span style="font-size: 1.1em;">66 Yrs.</span>						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Hat Trimmer</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.1em;">Conrad</span>						14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Emma</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.1em;">Mrs. Carolyn Armstrong, 929 Wilton Drive,</span>			
18. <span style="font-size: 1.2em;">420.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Ac. Coronaries thrombosis</span> DUE TO (B) <span style="font-size: 1.2em;">Hypertension, Arterio</span> DUE TO <span style="font-size: 1.2em;">Sclerotic C. V. Disease</span> (C)				INTERVAL BETWEEN ONSET AND DEATH	
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Oct. 8, 1964</span> to <span style="font-size: 1.1em;">May 1, 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">May 1, 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <span style="font-size: 1.2em;">Albin Klimas</span> M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">May 3, 65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Dr. Albin Klimas</span>						23D. ADDRESS <span style="font-size: 1.1em;">2030 Wilkens Avenue, Baltimore, Md. 21223</span>					
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>				24B. DATE <span style="font-size: 1.1em;">5/5/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Western Cemetery</span>				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 5 1965</span>				25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>				25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Howard H. Hubbard</span>			
ADDRESS <span style="font-size: 1.1em;">21229</span>											



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

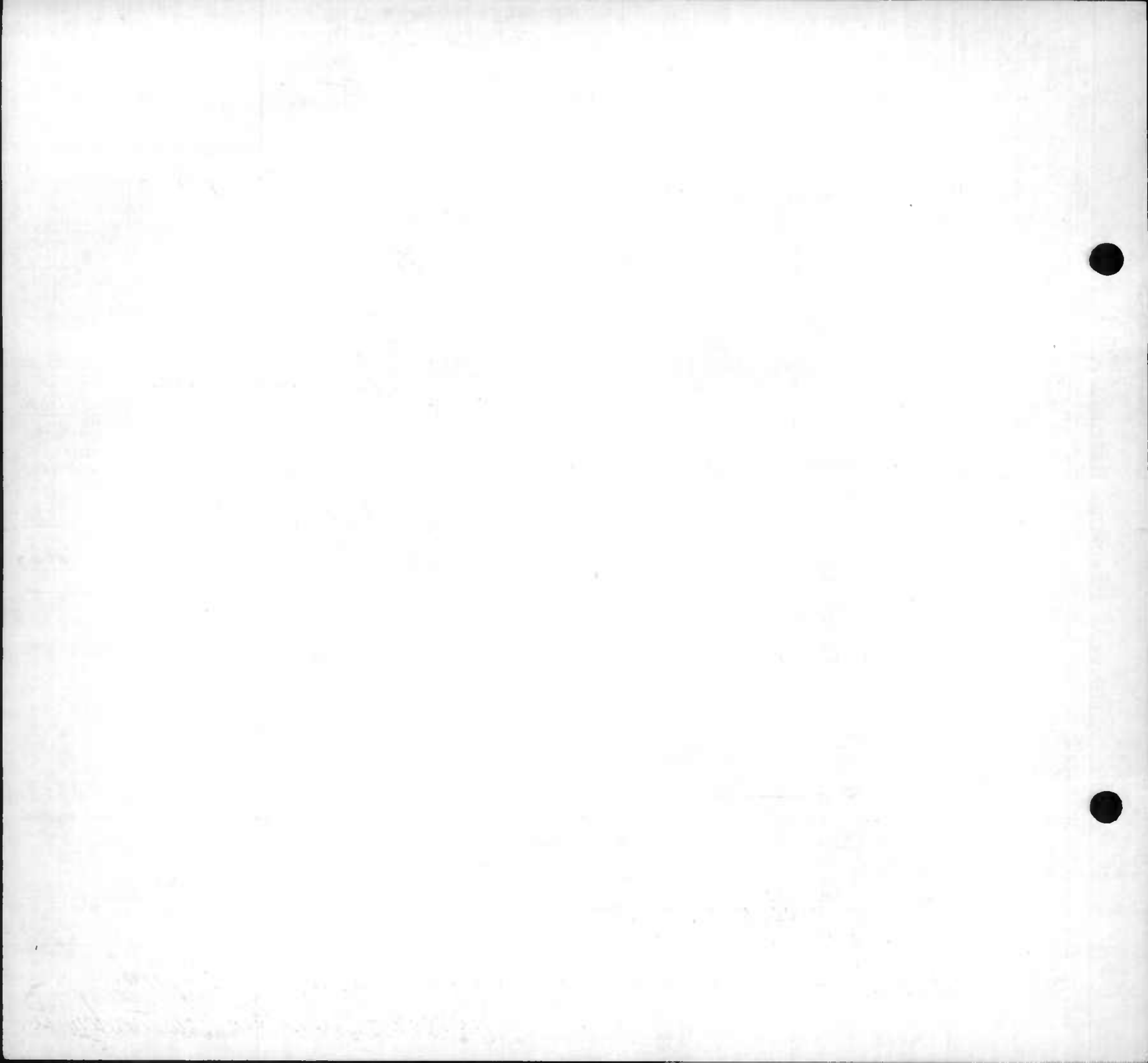
BALTIMORE CITY HEALTH DEPARTMENT									
C-5401 CERTIFICATE OF DEATH					Registered No. 65 4774				
1. NAME OF DECEASED (Type or Print) <b>Terence J. Connolly</b>					2. DATE AND HOUR OF DEATH <b>May 2, 1965</b> at <b>4:15</b> a.m.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>17 The Seton Psychiatric Institute 6420 Reisterstown Road Baltimore, Maryland 21215</b>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>New Jersey</b> B. COUNTY <b>Union City</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Union City</b> D. STREET ADDRESS (If rural, give location) <b>1901 West Street</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>August 24, 1898</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Catholic Priest</b>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>			12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>Patrick Connolly</b>					14. MOTHER'S MAIDEN NAME <b>Mary Harkins</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Robert H. Connolly, Son</i>				ADDRESS
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic diffuse glomerulonephritis over 4 years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>about 8 years</b>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic undifferentiated type Schizophrenic Reaction</b>					37 years				
19A. DATE OF OPERATION <b>○</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>January 22, 1930</b> to <b>May 2, 1965</b> , that (I) (we) last saw the deceased alive on <b>May 2, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Walter O. Jahrreiss</i>					M.D. Attending Phys. <input type="checkbox"/> for Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <b>May 2, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss</b>					23D. ADDRESS M.D. <b>6420 Reisterstown Rd., Baltimore, Maryland</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>			24B. DATE <b>5-3-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Boston</b>			24D. LOCATION (City, town, or county) (State) <b>Manchester, New Hampshire</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>			25B. NAME OF REGISTRAR <i>Robert E. Jahrreiss</i>			25C. FUNERAL DIRECTOR <i>Joseph J. Jahrreiss</i>			ADDRESS <i>Home - Catonsville, Md.</i>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4775				
BIRTH NO. 65 4775									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>LAURA LORETTA HOFFMAN</u>					2. DATE AND HOUR OF DEATH <u>4-15 PM</u> <u>4/29/65</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNION MEMORIAL Hospital</u>					A. STATE <u>MARYLAND</u>				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>PARKTON (RURAL)</u> <u>6300</u>				
					D. STREET ADDRESS (If rural, give location) <u>Middletown Rd.</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u>	8. DATE OF BIRTH <u>8/10/87</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Riggeal</u>					14. MOTHER'S MAIDEN NAME <u>MARY JANE</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Grayson Hare</u> <u>daughter - Box 1 Rt. 1</u>				
					ADDRESS <u>Freeland Md.</u>				
18. <u>286.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EDEMA</u>					CAUSE OF DEATH (A) <u>PULMONARY EDEMA</u> DUE TO <u>12 hours</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CORONARY INSUFFICIENCY</u>					(B) <u>CORONARY INSUFFICIENCY</u> DUE TO <u>-</u>				
					(C) <u>MALNUTRITION + DEHYDRATION</u> <u>6-8 months</u>				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>4/26</u> 19 <u>65</u> to <u>4/29</u> 19 <u>65</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>4/29</u> 19 <u>65</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <u>William N. Bennett</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>4/29/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM N. BENNETT</u> <u>WILLIAM N. BENNETT</u>					23D. ADDRESS <u>Union Memorial Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-2-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wiseburg Cemetery</u>			24D. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Jacob H. Weinstein</u>			
ADDRESS <u>New Freedom, Pa.</u>									



BIRTH NO. 65 4776

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No. 65 4776

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

A.

NELLIE WOODS

2. DATE AND HOUR PRONOUNCED DEAD

May 3, 1965

6:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4200 Loch Raven Blvd. Apt 463

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Feb. 7, 1889

9. AGE (In years  
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

(unknown)

Bankerd

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Wm.H.Woods, 623 Hastings Rd., Towson 21204, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
DUE TO cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-6-65

23C. NAME of CEMETERY or CREMATORY

Druid Ridge Cemetery

23D. LOCATION (City, town, or county)

(State)

Pikesville 21208

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Jasky, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc., 1217 St. Paul Street

WATERBURY POLICE

WATERBURY POLICE

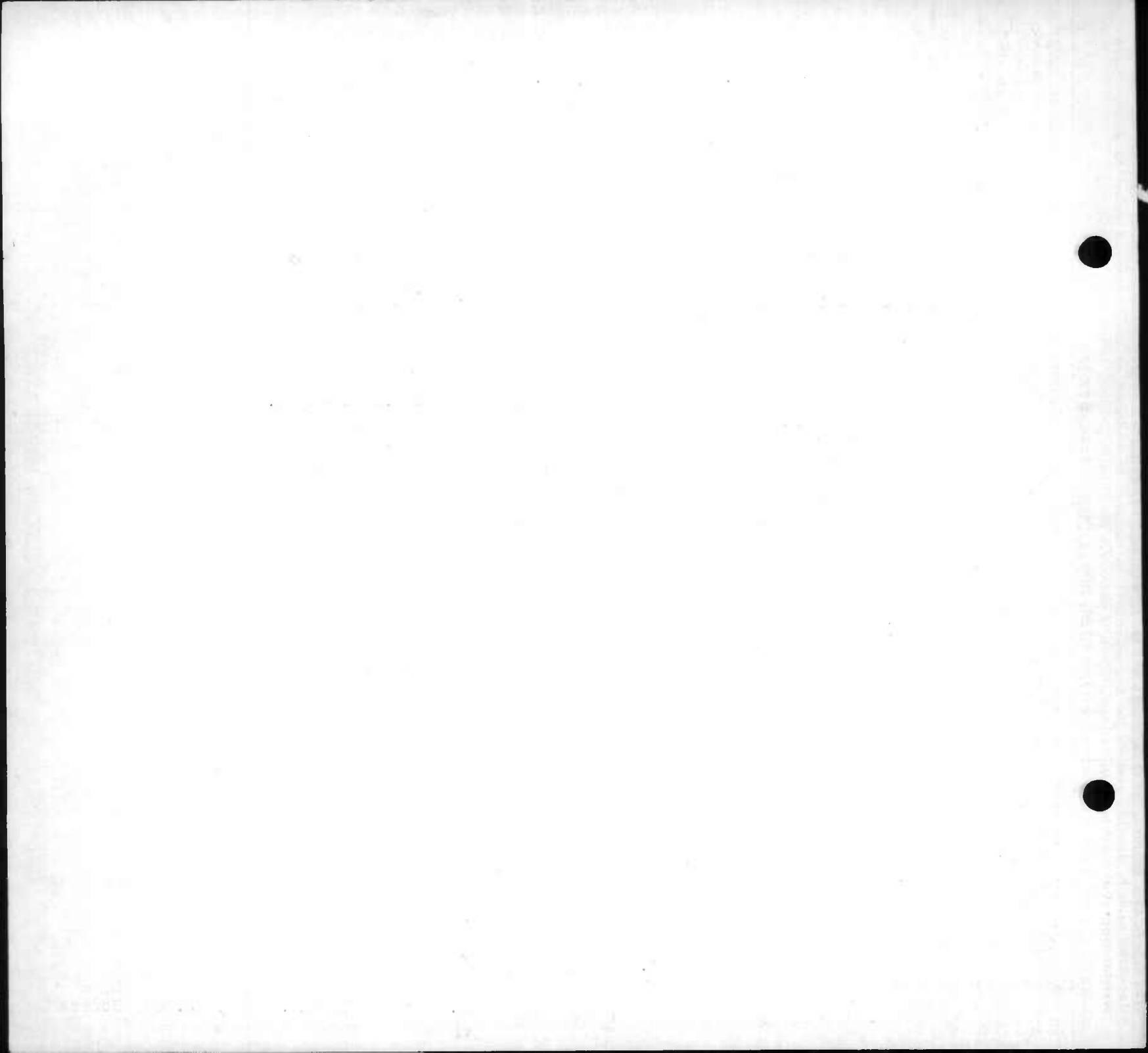
TO THE HONORABLE JUDGE OF THE DISTRICT COURT  
AT WATERBURY, CONNECTICUT  
FROM THE DISTRICT ATTORNEY  
OF THE DISTRICT OF COLUMBIA  
RE: [Illegible text]

[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a legal opinion or memorandum.]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4777		65 4777	
CERTIFICATE OF DEATH				Registered No.			
BIRTH NO. 65 4777				DATE AND HOUR OF DEATH 5/4/65 1:00 A.M.			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) WILBERT J. ELSROAD, Sr.				5/4/65 1:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital				A. STATE Md. B. COUNTY Baltimore			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1708 Light St. 23-03			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5-23-1908	9. AGE (In years lost birthday) 56	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Elsroad				14. MOTHER'S MAIDEN NAME Margaret KATLY Wigman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-10-0997		17. INFORMANT ADDRESS Wilbert J. Elsroad, Jr., Pasadena, Maryland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				INTERVAL BETWEEN ONSET AND DEATH			
(A) DUE TO Massive Bleeding							
(B) DUE TO peptic ulcer							
(C) DUE TO pulmonary tuberculosis							
19. ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 3 1965 to May 4 1965, that (I) (we) last saw the deceased alive on May 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Esteban G. Frieria				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-4-65	
23C. PHYSICIAN'S NAME (Type) ESTEBAN G. FRIERIA				23D. ADDRESS M.D. 1213 Light St. Balto 30 MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-6-65		24C. NAME OF CEMETERY or CREMATORY St. Paul Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965		25B. NAME OF REGISTRAR Robert E. Jarboe		25C. FUNERAL DIRECTOR Wm. Cook-Brooks, Inc., 1217 St. Paul Street		ADDRESS	



BIRTH NO.

65

4778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

4778

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

IRVING E. HILL

2. DATE AND HOUR PRONOUNCED DEAD

5-3-65

12:20 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1722 Aliceanna Street 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

March 16, 1914

9. AGE (In years  
last birthday)

51

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

(disabled)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Hill

14. MOTHER'S MAIDEN NAME

Esther May

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

220-09-0832

17. INFORMANT

ADDRESS

Mrs. Esther B. Hill, 1722 Aliceanna St, 21231

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER

DATE SIGNED  
5-3-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

5-6-65

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

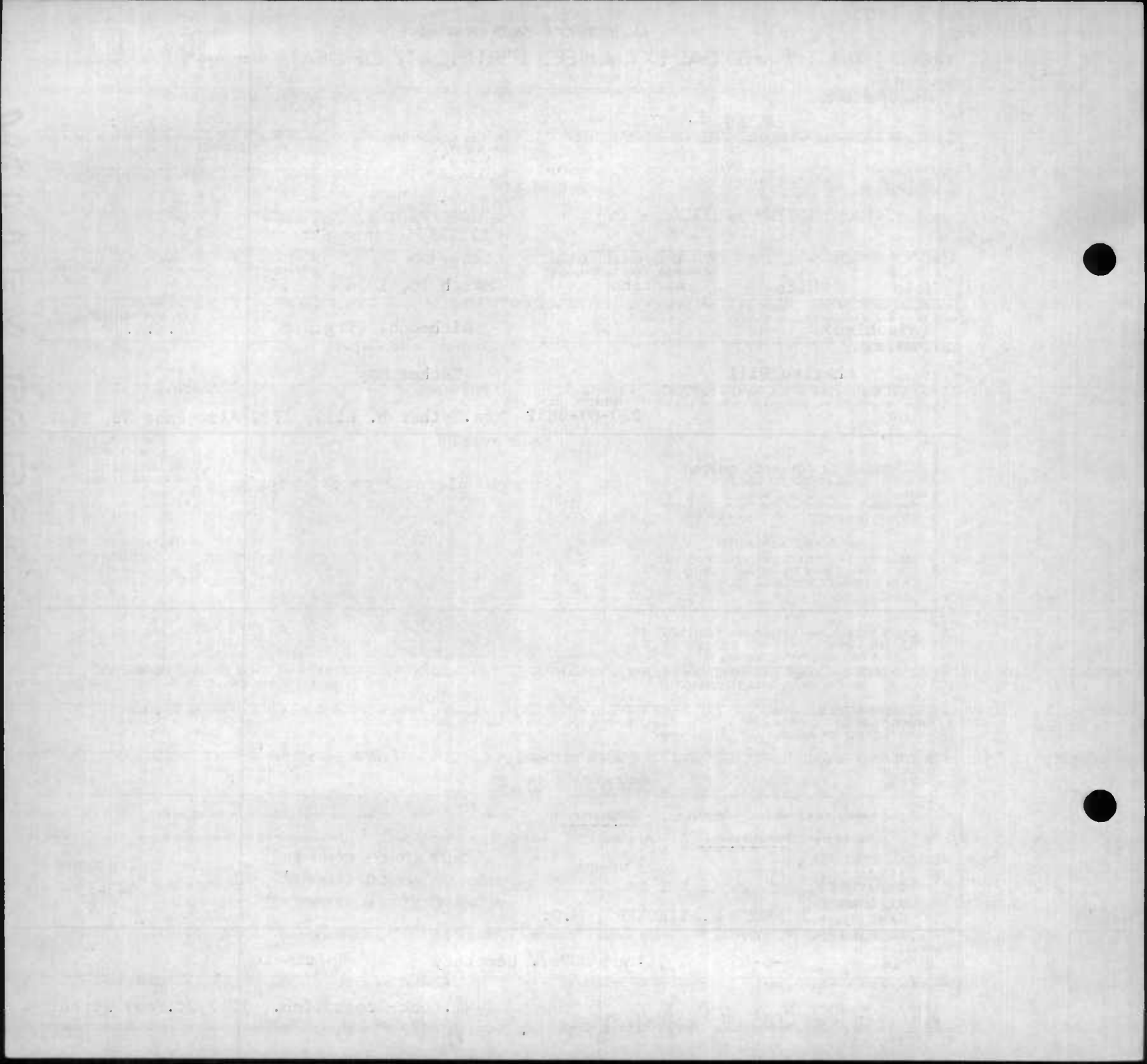
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

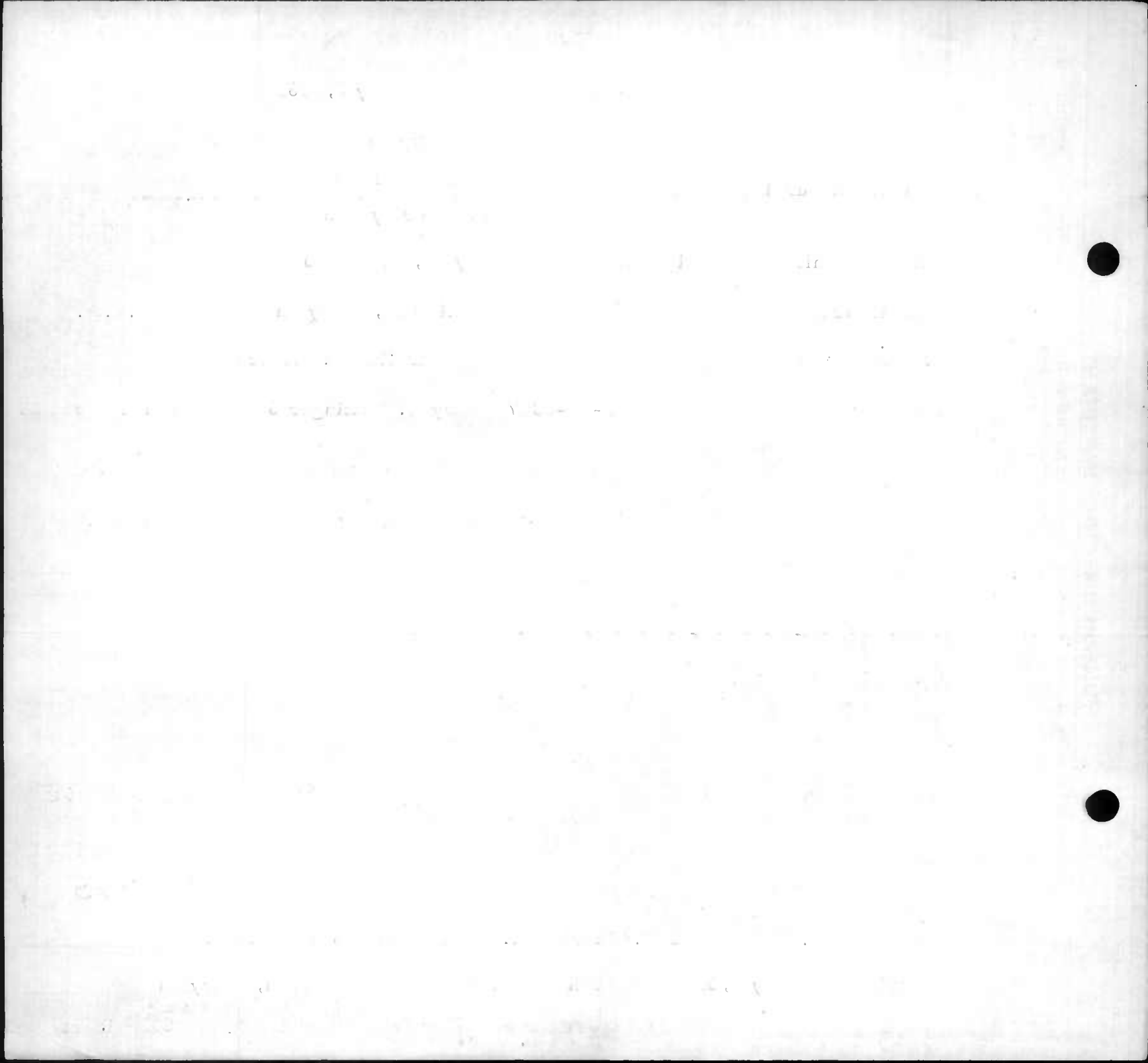
MAY 5 1965

Wm. Cook-Brooks, Inc., 1217 St. Paul Street



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT												
CERTIFICATE OF DEATH					Registered No. 65 4779							
BIRTH NO. 65 4779		M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>CARROLL FREDERICK SMALL</b>					2. DATE AND HOUR OF DEATH <b>May 2, 1965</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>Anderson Nursing Home</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltr</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Randallstown</b> D. STREET ADDRESS (If rural, give location) <b>5300 3702 Durley Lane</b>					5. SEX <b>Male</b>		
6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widower</b>			8. DATE OF BIRTH <b>May 13, 1902</b>		9. AGE (In years last birthday) <b>62</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>Stewart Small</b>					14. MOTHER'S MAIDEN NAME <b>Caroline A. Radecke</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>215-03-3847</b>		17. INFORMANT <b>Mary K. Hottinger 6028 Moorehead Road 28</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>154X I</b> <b>Carcinomatosis</b> <b>2 yrs</b>					CAUSE OF DEATH (A) DUE TO <b>Carcinoma Rectosigmoid</b> <b>2 yrs</b> (B) DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>02-10-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Exploratory Laparotomy</b>			20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1938</b> to <b>May 2, 1965</b> , that (I) (we) last saw the deceased alive on <b>May 2, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>5:20 P.M.</b>		23A. SIGNATURE <b>Robert H. Siver</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-4-65</b>					
23C. PHYSICIAN'S NAME (Type) <b>ROBERT H. SIVER 3105 N. Charles St.</b>					23D. ADDRESS <b>3105 North Charles Street</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 5, 65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>		25B. NAME OF REGISTRAR <b>Ellsworth Armacost</b>			25C. FUNERAL DIRECTOR'S ADDRESS <b>ELLSWORTH ARMAGOST 4600 Liberty Hgh</b>							



1

65 4780

BALTIMORE CITY HEALTH DEPARTMENT

65 4780

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES DELAWARE

2. DATE AND HOUR PRONOUNCED DEAD

5-3-65

11:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. JOSEPH'S HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1839 N. Castle Street 21213

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept 16, 1916

9. AGE (In years  
last birthday)

24

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemp Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Roland L. Delaware

14. MOTHER'S MAIDEN NAME

Blanche L. Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Alonge West 1815 N. Castle St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Gunshot wounds of chest

with bilateral hemothorax

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

In front of 1815 N. Castle St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year)  
5 2 '6511:30  
PM.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during alter-  
cation over seat on steps

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-3-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 6 1965

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

(City, town, or county)

(State)

Westport Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

Z. T. Ellickson 1129 N. Calvert

ADDRESS



VALLEY FORD

PAID UNIT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

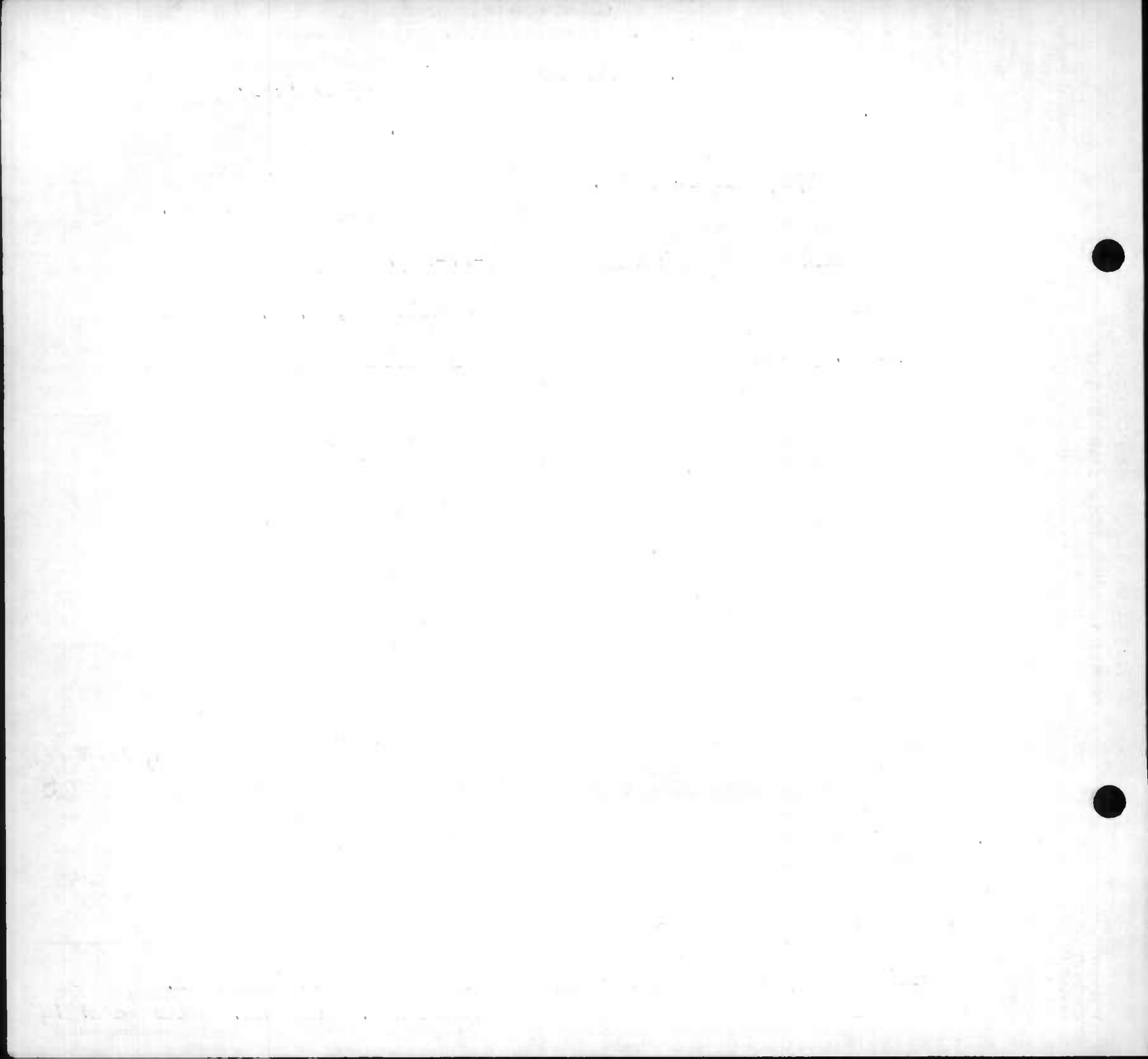
BALTIMORE CITY HEALTH DEPARTMENT														
65 4781					CERTIFICATE OF DEATH					Registered No. 65 4781				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)				
					McIntyre, Metta (Metter)					2. DATE AND HOUR OF DEATH May 1, 1965 5:35 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  St. Joseph Hospital										Maryland 9-09				
										C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #2				
										D. STREET ADDRESS (If rural, give location) 1503 N. Aisquith St.				
5. SEX Female		6. RACE Negro		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Dec. 11 1913		9. AGE (In years last birthday) 51		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) N. Carolina				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME Mack Harris					14. MOTHER'S MAIDEN NAME Anna Merritt				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT King McIntyre				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X I					CAUSE OF DEATH (A) <del>Diabetes mellitus; pneumococcus pneumonia; severe generalized arteriosclerosis; multiple infarcts, left ventricle and cerebrums</del> (B) <del>Diabetes mellitus; pneumococcus pneumonia; severe generalized arteriosclerosis; multiple infarcts, left ventricle and cerebrums</del> (C) <del>Diabetes mellitus; pneumococcus pneumonia; severe generalized arteriosclerosis; multiple infarcts, left ventricle and cerebrums</del>					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION 2					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) Yes				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from April 28, 19 65 to May 1, 19 65, that (I) (we) last saw the deceased alive on May 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William B. VandeGrift					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED May 2, 1965				
23C. PHYSICIAN'S NAME (Type) William B. VandeGrift					M.D. 23D. ADDRESS 1400 N. Caroline St., 21213									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE May 6/65					24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery				
24D. LOCATION (City, town, or county) (State) A. A. County Md					25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965					25B. NAME OF REGISTRAR Robert E. Parker				
25C. FUNERAL DIRECTOR Morton E. Barker					ADDRESS 127 N. Caroline St.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

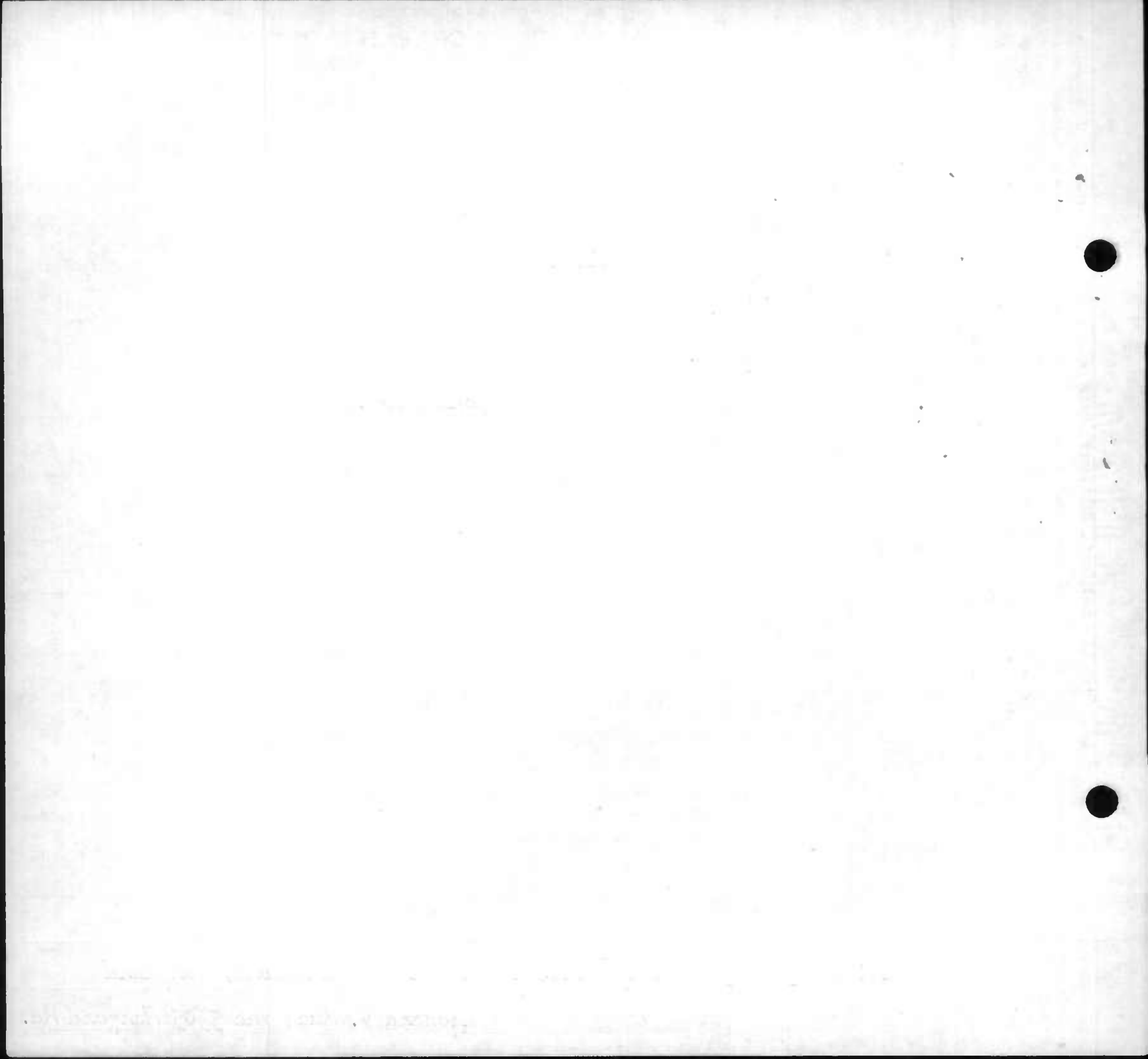
BALTIMORE CITY HEALTH DEPARTMENT									
65 4782 CERTIFICATE OF DEATH					Registered No. 65 4782				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Anna E. Quintero					May 4, 1965.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  2724 Maryland Ave.					A. STATE Md.				
					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 2724 Maryland Ave.				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
female	white	Divorced	4-11-1891	74					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
at home					Washington, D. C.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Edgar P. Gwynn					Francina Matthews				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO			12/15/54	
ANTECEDENT CAUSES					(B) DUE TO			1/15/64	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from 12/15/54 to April 26, 1965.					that (I) lost saw the deceased alive on April 26, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
M.B. Levin								May 5/65	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS						
M.B. LEVIN, M.D.			218 E. University Pkwy						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
burial				Parkwood Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS	
MAY 5 1965			Robert E. Fisher		Lepnyrd J. Ruck Inc.			Balto Md 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

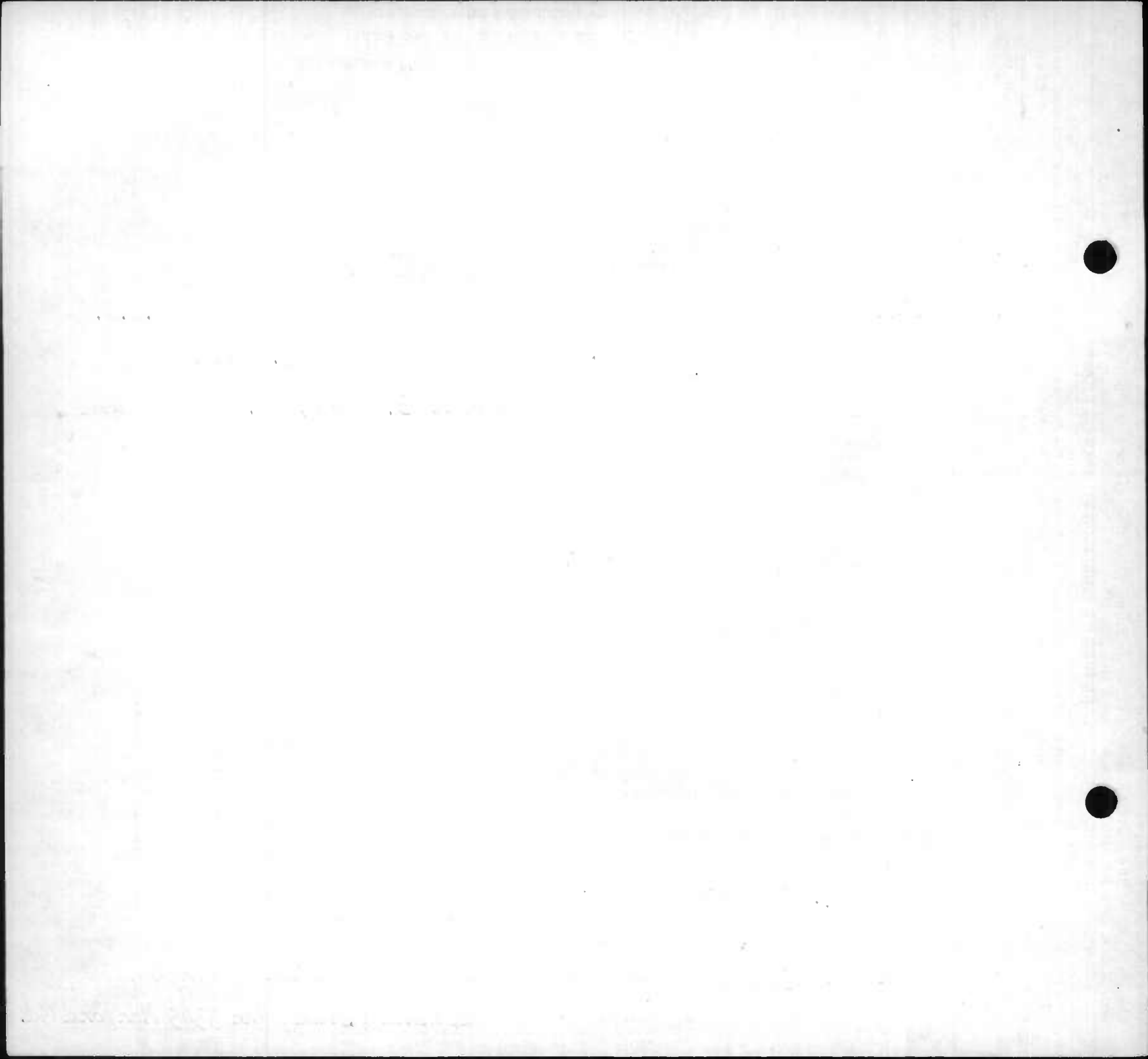
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>65-11610</u>		65 4783		CERTIFICATE OF DEATH		Registered No. <u>65 4783</u>			
M.E. CASE NO.						2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>BABY GIRL SCHWARZ</u>						5-4-65 7:15 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u>						A. STATE <u>MARYLAND</u>			
(If not in hospital or institution, give street address or location)						B. COUNTY			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
						<u>BALTIMORE</u>			
						D. STREET ADDRESS (If rural, give location)			
						<u>228 Rodgers, Forge Rd.</u>			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
<u>F</u>	<u>W</u>	<u>Single</u>		<u>5-4-65</u>				<u>89</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<u>CHILD</u>				<u>MARYLAND</u>		<u>U.S.A.</u>			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
<u>J. SCOTT SCHWARZ</u>						<u>Josephine Cascio</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
						<u>John Schwarz</u>			
18. <u>726X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)						<u>8 1/2 hrs</u>			
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
<u>0</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>5-4 (10:30 AM) 1965</u> to <u>5-4 (7:15 PM) 1965</u> , that (I) (we) last saw the deceased alive on <u>5-4</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
<u>Emelda B. Galanis</u>						<u>5-4-65</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				<u>Mercy Hospital, Balto. Md</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>5/6/65</u>		<u>Holy Redeemer Cemetery</u>		<u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<u>MAY 5 1965</u>		<u>Robert E. Faltus</u>		<u>Leonard J. Ruck Inc</u>		<u>5305 Harford Rd.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4784		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4784	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) JEWER ROBERT			MAY 4, 1965 2:20 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hosp.			A. STATE MARYLAND B. COUNTY BALTIMORE		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 3209 GLENMOORE AVE #14		
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11/24/65	9. AGE (In years last birthday) 64	10. AGE (In years last birthday) 5 10
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			11. BIRTHPLACE (State or foreign country) MARYLAND		
10B. KIND OF BUSINESS OR INDUSTRY —			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT JEWER Sr.			14. MOTHER'S MAIDEN NAME VIRGINIA E. Marsh		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —			16. SOCIAL SECURITY NO. —		
			17. INFORMANT Robert F. Jewer, Sr.		
			ADDRESS same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA			CAUSE OF DEATH (A) PNEUMONIA (B) PNEUMONIA (C) —		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. —			INTERVAL BETWEEN ONSET AND DEATH —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. WEDDIG. HOFFMANN					
19A. DATE OF OPERATION —		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4-28 19 65 to 5-4 19 65, that (I) (we) last saw the deceased alive on 5-4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sherman S. Chang				23B. DATE SIGNED 5/4/65	
23C. PHYSICIAN'S NAME (Type) SHERMAN S.M. CHANG				23D. ADDRESS Sinai Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/65		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR —		24F. FUNERAL DIRECTOR Leonard J. Ruck Inc 5305 Harford Rd.	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965		25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR —	

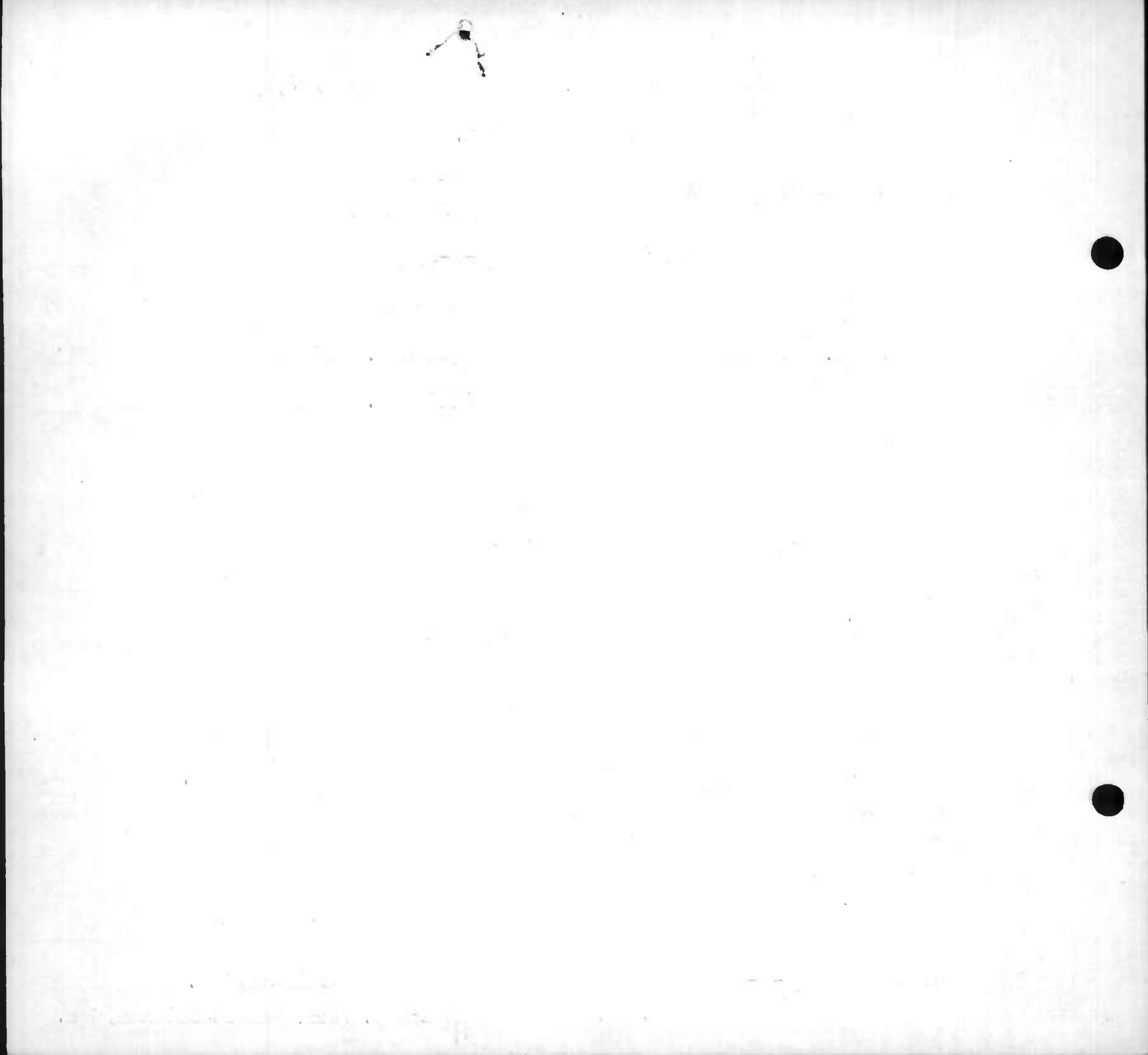




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

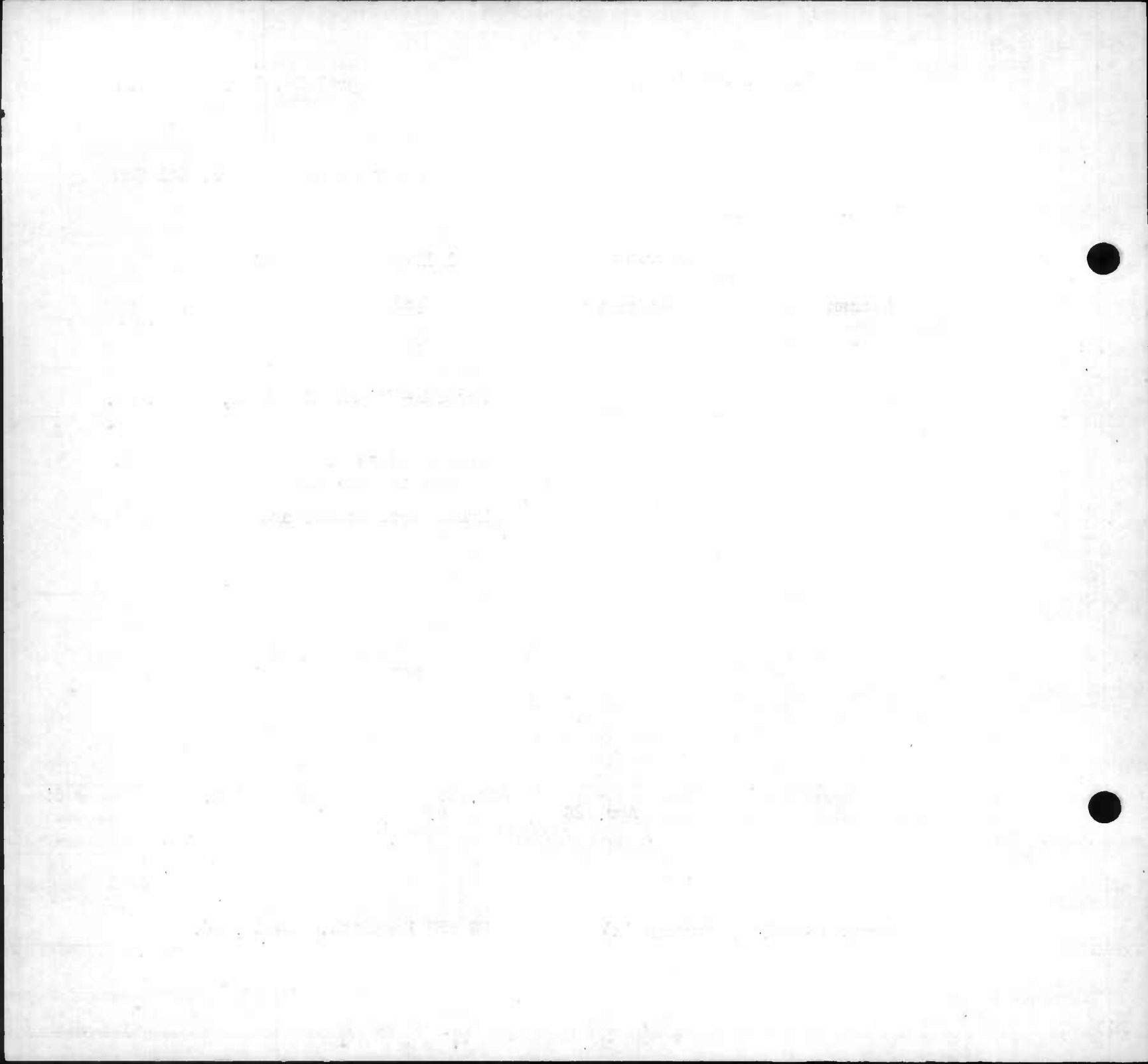
BALTIMORE CITY HEALTH DEPARTMENT									
C-540 1 65 4785 CERTIFICATE OF DEATH					Registered No. 65 4785				
BIRTH NO. 65 4785					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>Daisy Naomi Connelly</i>					2. DATE AND HOUR OF DEATH <i>May 3, 1965 6:25 P. M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <i>3016 Northway Drive</i>					A. STATE <i>Md.</i>				
					B. COUNTY				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>3016 Northway Drive</i>				
5. SEX <i>female</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>5-8-1885</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Robert L. Perkins</i>			14. MOTHER'S MAIDEN NAME <i>Ellen C. Mainley</i>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <i>William V. Connelly</i>		ADDRESS <i>same</i>		
18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>Atherosclerotic C-V disease</i> DUE TO (B) <i>Cerebral arteriosclerosis</i> (C) <i>Chronic Brain Syndrome</i> <i>Terminal uremia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>20 yrs</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>6/2</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>March 20</i> 19 <i>65</i> to <i>May 3</i> 19 <i>65</i> . that (I) ( <del>was</del> ) lost saw the deceased alive on <i>May 2</i> 19 <i>65</i> and that in ( <del>my</del> ) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.									
23A. SIGNATURE <i>H. V. Harbold</i> M.D.						23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>H. V. HARBOLD</i> M.D.						23D. ADDRESS <i>4706 HARFORD Rd Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>5-6-65</i>		24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>			25C. FUNERAL DIRECTOR <i>Legnard J. Ruck Inc Baltimore, Md.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 4786					CERTIFICATE OF DEATH					Registered No. 65 4786									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>Juan Alonzo Gonzalez</b>					2. DATE AND HOUR OF DEATH <b>April 28, 1965 1:33 A.M.</b>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Spain</b> B. COUNTY <b>V-72</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Monte Muino Barona P. Del Son</b>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Public Health Service Hospital Wyman Pk. Drive &amp; 31st Street</b>					D. STREET ADDRESS (If rural, give location) <b>12-06</b>														
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>1/17/31</b>		9. AGE (In years last birthday) <b>34</b>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Seafaring</b>					11. BIRTHPLACE (State or foreign country) <b>Spain</b>									
12. CITIZEN OF WHAT COUNTRY? <b>Spain</b>					13. FATHER'S NAME <b>?</b>					14. MOTHER'S MAIDEN NAME <b>?</b>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>					16. SOCIAL SECURITY NO. <b>none</b>					17. INFORMANT ADDRESS <b>Records= US PHS Hospital, Balto, Md.</b>									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema and bronchial pneumonia</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>										19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Intracerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>yes</b>									
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)									
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
21F. HOW DID INJURY OCCUR?					22. I certify that (1) (this hospital) attended the deceased from <b>Apr. 25</b> 19 <b>65</b> to <b>Apr. 28</b> 19 <b>65</b> , that (1) (we) last saw the deceased alive on <b>Apr. 28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					23A. SIGNATURE <i>Aaron Lupovitch</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>									
23B. DATE SIGNED <b>5/4/65</b>					23C. PHYSICIAN'S NAME (Type) <b>Aaron Lupovitch, Surgeon (R)</b> M.D.					23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE					24C. NAME of CEMETERY or CREMATORY									
24D. LOCATION (City, town, or county) (State) <b>La Corunna - Spain</b>					25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>									
25C. FUNERAL DIRECTOR <b>John S. Miller Inc. - 6415 Balan Rd</b>					25D. ADDRESS														



1

65 4787

BALTIMORE CITY HEALTH DEPARTMENT

65 4787

BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

Archie KENNETH MARTIN

2. DATE AND HOUR PRONOUNCED DEAD

May 1, 1965

5:20 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Church Home &amp; Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2214 E. Pratt Street

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 18, 1945

9. AGE (In years  
last birthday)

19 yrs.

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Box Factory

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James P. Martin

14. MOTHER'S MAIDEN NAME

Edith Powell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edith Langan

619 S. Patterson Park Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Tower

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Pagoda Tower, Patterson Park

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

5 1 65 5:18 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently fell

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-2-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 6, 1965

23C. NAME of CEMETERY or CREMATORY

Damascus Church Cemetery

23D. LOCATION

(City, town, or county)

(State)

Big Cove Tannery, Pa.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Jasky

24C. FUNERAL DIRECTOR

Raymond L. Kaczorowski

ADDRESS

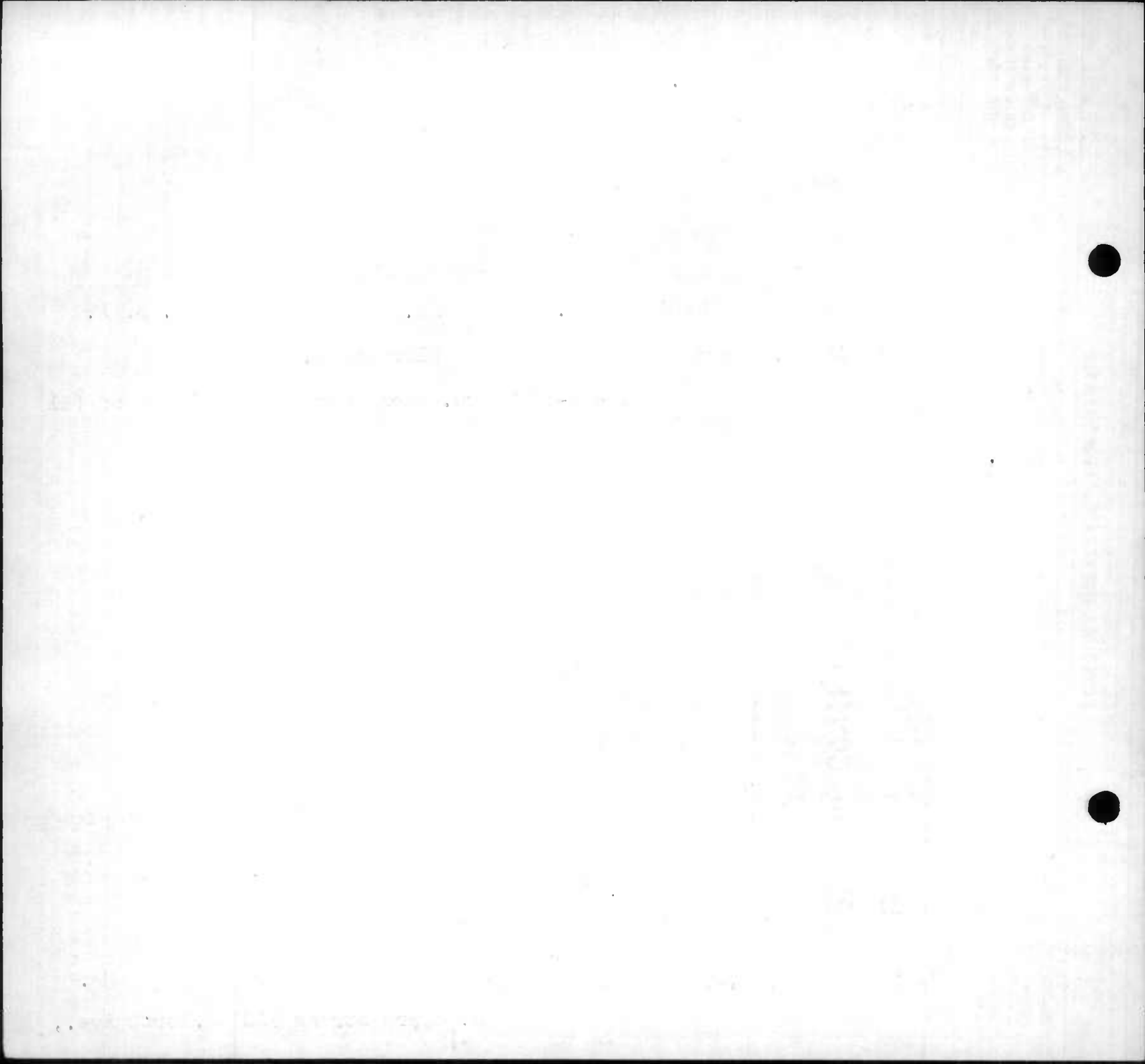
2525 Fleet St.

WALL NEW YORK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
65 4788					CERTIFICATE OF DEATH					Registered No. 65 4788				
BIRTH NO.					M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) <b>WILLIAM S. LUERS</b>				
2. DATE AND HOUR OF DEATH <b>5/4/65 7:15 pm.</b>					3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Union Memorial Hosp.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3731 Falls Rd</b>				
5. SEX <b>M</b>		6. RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>		8. DATE OF BIRTH <b>2/13/16</b>		9. AGE (In years last birthday) <b>49</b>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>T.V. repair</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>Radio &amp; Tel.</b>					11. BIRTHPLACE (State or foreign country) <b>Md.</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					13. FATHER'S NAME <b>William A. Luers</b>					14. MOTHER'S MAIDEN NAME <b>Florence M.</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO. <b>214-16-5597</b>					17. INFORMANT <b>Mrs. Helen Luers 3731 Falls Road (11)</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Ruptured Abdominal Aortic Aneurysm</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <b>No</b>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <b>5/4/65</b> 19 to <b>5/4/65</b> 19, that (I) (we) last saw the deceased alive on <b>5/4/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <b>C. Wallace C.B. Wallace</b>					23B. DATE SIGNED <b>5/4/65</b>					23C. PHYSICIAN'S NAME (Type) <b>S. SAMMAN</b>				
23D. ADDRESS <b>Union Memorial Hosp.</b>					24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					24B. DATE <b>May 7, 1965</b>				
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>					24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>					25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>				
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>					25C. FUNERAL DIRECTOR <b>G. Howard Strong 3207 W. North Ave.,</b>					25D. ADDRESS				





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 4789</span>					
BIRTH NO. <span style="font-size: 1.2em;">65 4789</span>										
M.E. CASE NO.										
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">WILLIAM GREEN</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">5-2-65 5:45 P.M.</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">LUTHERAN HOSP. OF Md.</span>					A. STATE <span style="font-size: 1.2em;">MARYLAND</span>					
					B. COUNTY					
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>					
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1652 APPLETON ST.</span>					
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">C</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARR</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">2-9-93</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MINISTER</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">USA</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		
13. FATHER'S NAME <span style="font-size: 1.2em;">Unknown</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Unknown</span>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-48-4378</span>		17. INFORMANT <span style="font-size: 1.2em;">CHART. Estelle Green</span>			ADDRESS <span style="font-size: 1.2em;">Same</span>		
18. <span style="font-size: 1.2em;">445X1</span>					CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <span style="font-size: 1.2em;">CEREBRAL HEMORRHAGE - ACUTE</span>					
					(B) <span style="font-size: 1.2em;">MALIGNANT HYPERTENSION - CHRONIC</span>					
					(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span>					INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">-</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5-2-1965</span> to <span style="font-size: 1.2em;">5-2-1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-2-1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <span style="font-size: 1.2em;">Renato R Espina</span>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.2em;">5-2-65</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RENATO R ESPINA</span>					23D. ADDRESS <span style="font-size: 1.2em;">LUTHERAN HOSP OF MD.</span>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">5-6-65</span>		<span style="font-size: 1.2em;">Mt. Auburn</span>			<span style="font-size: 1.2em;">Baltimore Md.</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 5 1965</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Farley</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Arlington Shelly</span>			ADDRESS <span style="font-size: 1.2em;">1727 N. Monmouth St.</span>	

AST 214 M

10/10/2020 10:10 AM 10/10/2020 10:10 AM

BIRTH NO. 65 4790 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

M. WILLIAM PALMER

2. DATE AND HOUR PRONOUNCED DEAD

May 2, 1965

5:15 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2412 Liberty Heights Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

5-1-1898

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Danville, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Daniel Palmer

14. MOTHER'S MAIDEN NAME

Ella Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-05-9511

17. INFORMANT

ADDRESS

William M. Palmer 3305 Egeton Rd.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-2-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-5-65

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Lk. Baltimore

23D. LOCATION

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 5 1965

24B. NAME OF REGISTRAR

Robert E. Fink M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wilmington &amp; Phillips 1727 N. Monmouth

VALLEY FORGE

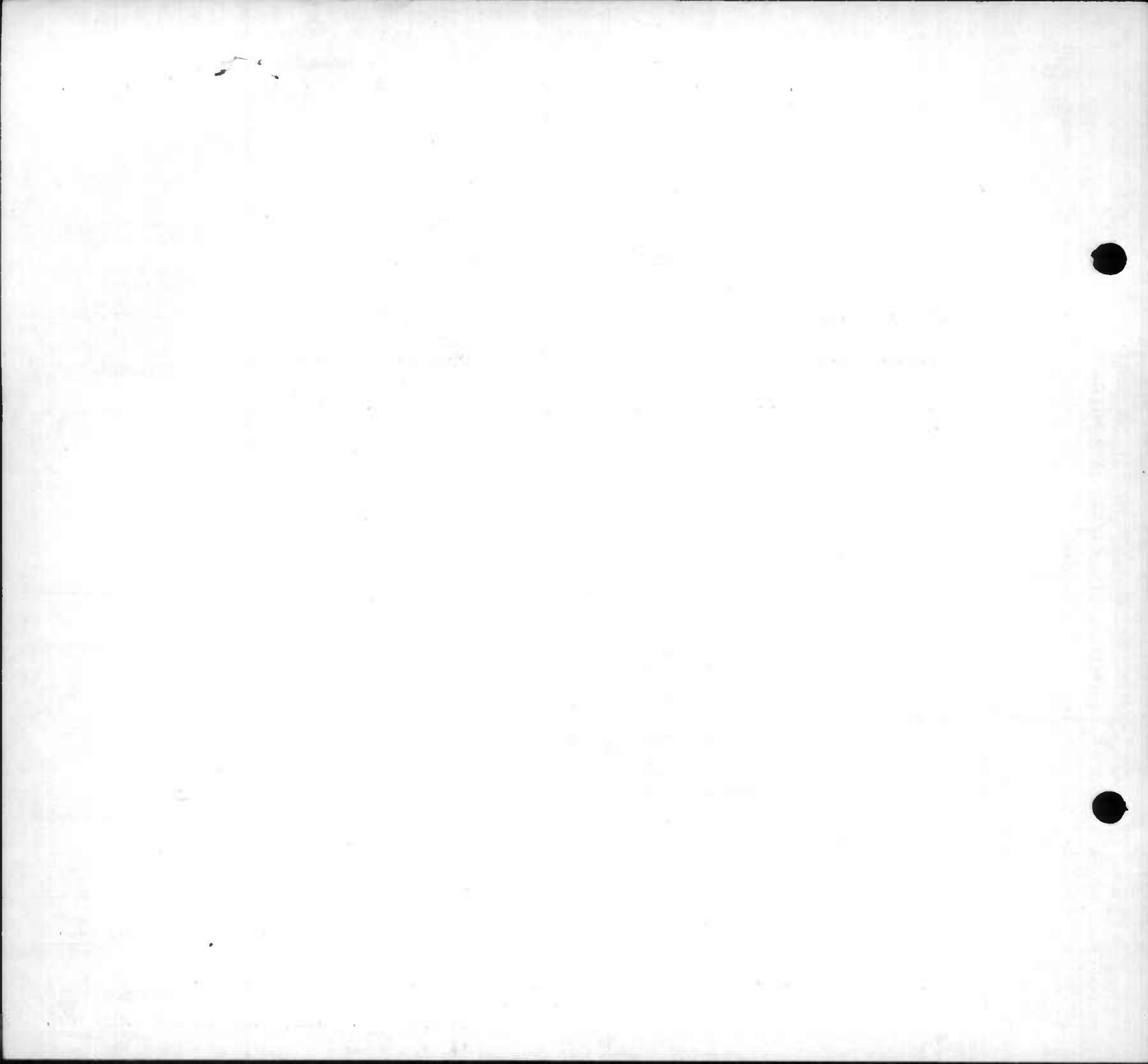
PAID DEPARTMENT

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4791									
M.E. CASE NO. 65 4791									
1. NAME OF DECEASED (Type or Print) A. Caleb Davis									
2. DATE AND HOUR OF DEATH May 3, 1965 13:15 A. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
Union Memorial Hospital					Md. 53-90				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore				
					D. STREET ADDRESS (If rural, give location)				
					3002 Taylor Ave.				
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
male		white		married		4-17-1910		55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Cemetery Counselor								West Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?	
Arthur Barr Davis				Vivie Margarete Wilhelm				USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes WW 11				212011440		Kathryn B. Davis		same	
18. 420.0 I CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D						no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?			
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from June 1963 to May 3, 1965, that (I) (we) last saw the deceased alive on April 25, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE								23B. DATE SIGNED	
George Sawyer M.D.								5/3/65	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS			
GEORGE SAWYER M.D.						4808 Harford Rd. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
burial			5-6-65		Gardens of Faith Cem.		Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
MAY 5 1965			Robert E. Taylor			Leonard J. Ruck Inc Baltimore, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH						Registered No. 65 4792					
BIRTH NO. 65 4792											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) <b>Antonio (None) Roma</b>						2. DATE AND HOUR OF DEATH <b>5-4-65 12 45 /A M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balt</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Hospital For the Women of Md.</b>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 5300</b>					
D. STREET ADDRESS (If rural, give location) <b>Dulancy Valley Nursing Home</b>											
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>2-5-05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butter</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Italy</b>			12. CITIZEN OF WHAT COUNTRY? <b>unknown</b>		
13. FATHER'S NAME <b>Joseph Roma</b>						14. MOTHER'S MAIDEN NAME <b>Ma Ghucco Maicco</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes unknown W.W. 2</b>						16. SOCIAL SECURITY NO. <b>218226040</b>			17. INFORMANT <b>Patients chart.</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Extensive metastatic Ca 1 1/2 yrs.</b>						CAUSE OF DEATH (A) DUE TO <b>Bronchogenic origin</b> (B) DUE TO (C) _____					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>						INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>No</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>May 1 1965</b> to <b>May 4 1965</b> , that (I) (we) last saw the deceased alive on <b>May 4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Zoo-Kei Chan</b> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>May 4, 1965</b>		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 5 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck Inc 5305 Harford Rd.</b>			

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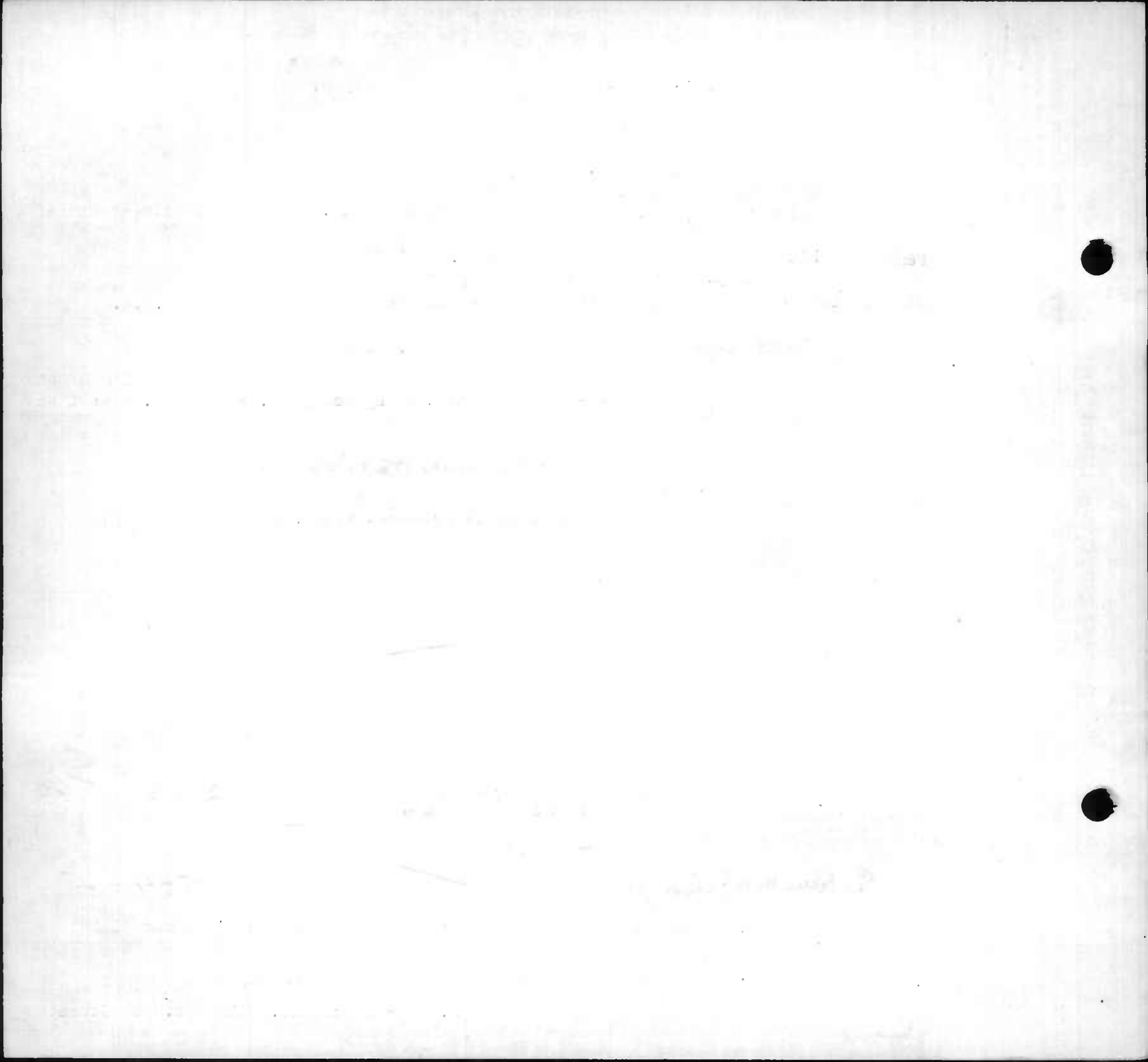




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4793					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4793				
1. NAME OF DECEASED (Type or Print) Mary E. Krekel					2. DATE AND HOUR OF DEATH May 4, 1965				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gilman Apartments (Apt. A-3) 3041 North Calvert Street Baltimore, Maryland 21218					A. STATE B. COUNTY Maryland 12-02				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218				
					D. STREET ADDRESS (If rural, give location) Gilman Apts., 3041 North Calvert Street				
5. SEX Female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single	8. DATE OF BIRTH Jan. 10, 1881	9. AGE (In years last birthday) 84	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired teacher)		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Louis Krekel					14. MOTHER'S MAIDEN NAME Mary E. Mankan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 220-4-2798				
17. INFORMANT Miss Dorothy Webb, Apt. A-3, 3041 N. Calvert St					ADDRESS Gilman Apts				
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					CAUSE OF DEATH (A) <u>Cerebrovascular Heart Disease, probable</u> DUE TO (B) <u>Cerebral vascular disease</u> DUE TO (C) _____				
					INTERVAL BETWEEN ONSET AND DEATH 6 yrs.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-59 19 to 2-12 1960, that (I) (we) last saw the deceased alive on 2-12 1960 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Hunter Wilson Jr.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5-4-65	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson, Jr					23D. ADDRESS 806 Medical Arts Building, Baltimore 21201				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5-7-65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965			25B. NAME OF REGISTRAR Robert E. Fairbank			25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc., 1217 St. Paul Street			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY DEPARTMENT											
BIRTH NO. 65 4794										Registered No. 65 4794	
CERTIFICATE OF DEATH											
1. NAME OF DECEASED (Type or Print) Mrs Mary Henderson						2. DATE AND HOUR OF DEATH 5/4/65 1:00 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp. Balto. Md						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 12-04					
5. SEX F						6. RACE G		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W.		8. DATE OF BIRTH 12/25/1904	
9. AGE (In years last birthday) 60						10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State of foreign country) So. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA.						13. FATHER'S NAME Charlie Mc Coy					
14. MOTHER'S MAIDEN NAME ??						15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO.						17. INFORMANT George Mc Coy					
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) DUE TO Cardiac Arrhythmia					
						(B) DUE TO CHF (electrolyte imbalance)					
						(C) DUE TO ASCVD & MI (recent + old)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						none					
19A. DATE OF OPERATION						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
20A. AUTOPSY? (Yes or No)						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						21D. TIME OF INJURY (Month) (Day) (Year) (Hour)					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3-28-65 to 5/4/65, that (I) (we) lost saw the deceased alive on 5/4/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Wm E Schwartz M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED 5/4/65					
23C. PHYSICIAN'S NAME (Type) Wm. E. Schwartz M.D.						23D. ADDRESS Mercy Hosp. Balto.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 5/7/65					
24C. NAME OF CEMETERY OR CREMATORY Balto Natl Cem						24D. LOCATION 5301 Fredrick Ave (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1965						25B. NAME OF REGISTRAR Robert E. Jankowski					
25C. FUNERAL DIRECTOR						25D. ADDRESS					
J. E. Erickson						11299 Carlinist					

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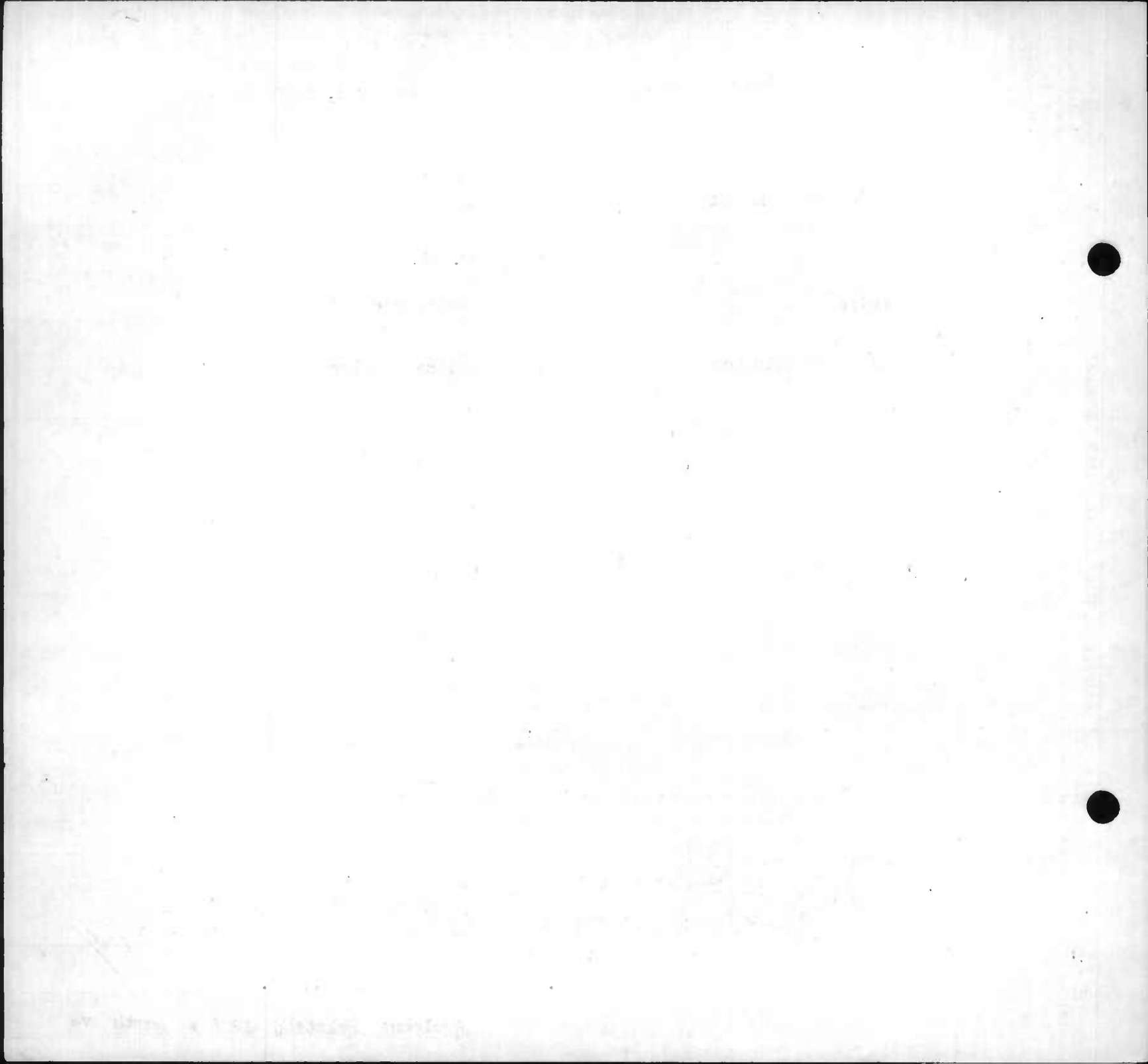
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M. F. Schwartz  
M. E. Ackroyd  
2/1/02  
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Merry Wood

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

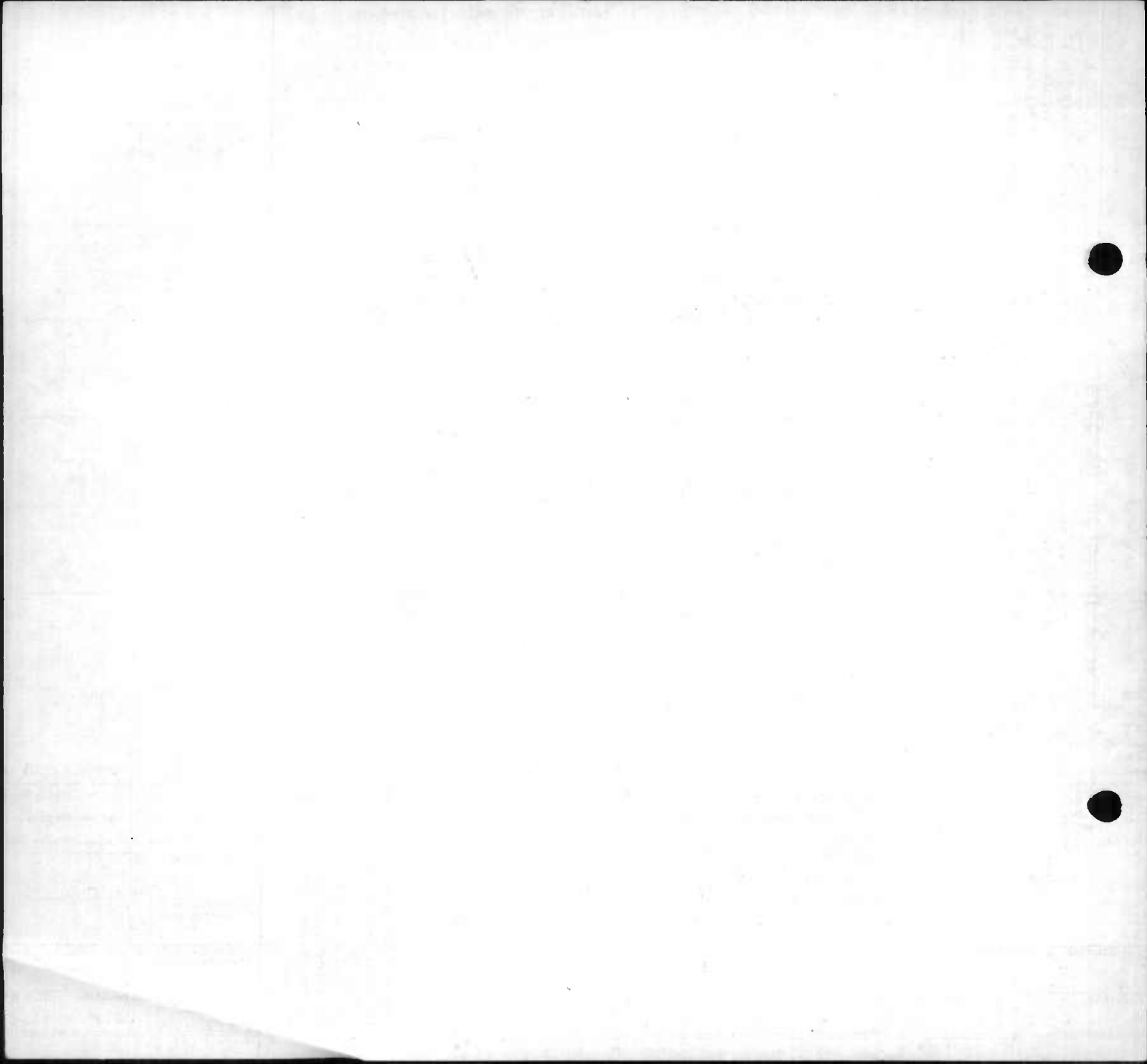
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 4795</span>				
BIRTH NO. <span style="font-size: 1.2em;">65 4795</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">May 1, 1965</span>				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mittie Green</span>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">804 Hollins St</span>					A. STATE <span style="font-size: 1.2em;">Md</span>				
					B. COUNTY <span style="font-size: 1.2em;">18-03</span>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>				
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">804 Hollins St</span>				
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">C</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov. 14, 1897</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">67</span>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore Md</span>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <span style="font-size: 1.2em;">John B Washington</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Eliza Fowler</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <span style="font-size: 1.2em;">260x I</span>  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH <span style="font-size: 1.2em;">Cardio Vascular Disease</span>			INTERVAL BETWEEN ONSET AND DEATH	
					(A) DUE TO <span style="font-size: 1.2em;">Diabetes Mellitus?</span>				
					(B) DUE TO				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Mar 19 65</span> to <span style="font-size: 1.2em;">May 1 19 65</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 25 19 65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>					23B. DATE SIGNED				
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">[Signature]</span>					23D. ADDRESS <span style="font-size: 1.2em;">403 Med Arts Bldg</span>				
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5/5/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Arbutus Mem. Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto., Md.</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 6 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Adolphus Halstead</span>			ADDRESS <span style="font-size: 1.2em;">1206 W North Ave</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4796		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4796	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MRS FRANCES BLACKWOOD		2. DATE AND HOUR OF DEATH 5/5/65 5:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 26-05		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME + HOSP.		D. STREET ADDRESS (If rural, give location) 6333 Hudson St.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 7/10/87	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY CROUSE + BLACK WELLS		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME MR. Eckert		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 312-09-7374		17. INFORMANT HOSPITAL CHART	
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CARCINOMATOSIS DUE TO (B) CANCER OF BREAST DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Approx 6 YRS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from May 2 19 65 to May 5 19 65, that (we) last saw the deceased alive on May 5 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. S. Gregory		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/5/65	
23C. PHYSICIAN'S NAME (Type) J. S. GREGORY		23D. ADDRESS Church Home + Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-65		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore Md		24E. FUNERAL DIRECTOR Legg Cook 1701 N. Patterson St			
25A. DATE RECEIVED BY HEALTH DEPT. MAY 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Legg Cook 1701 N. Patterson St	

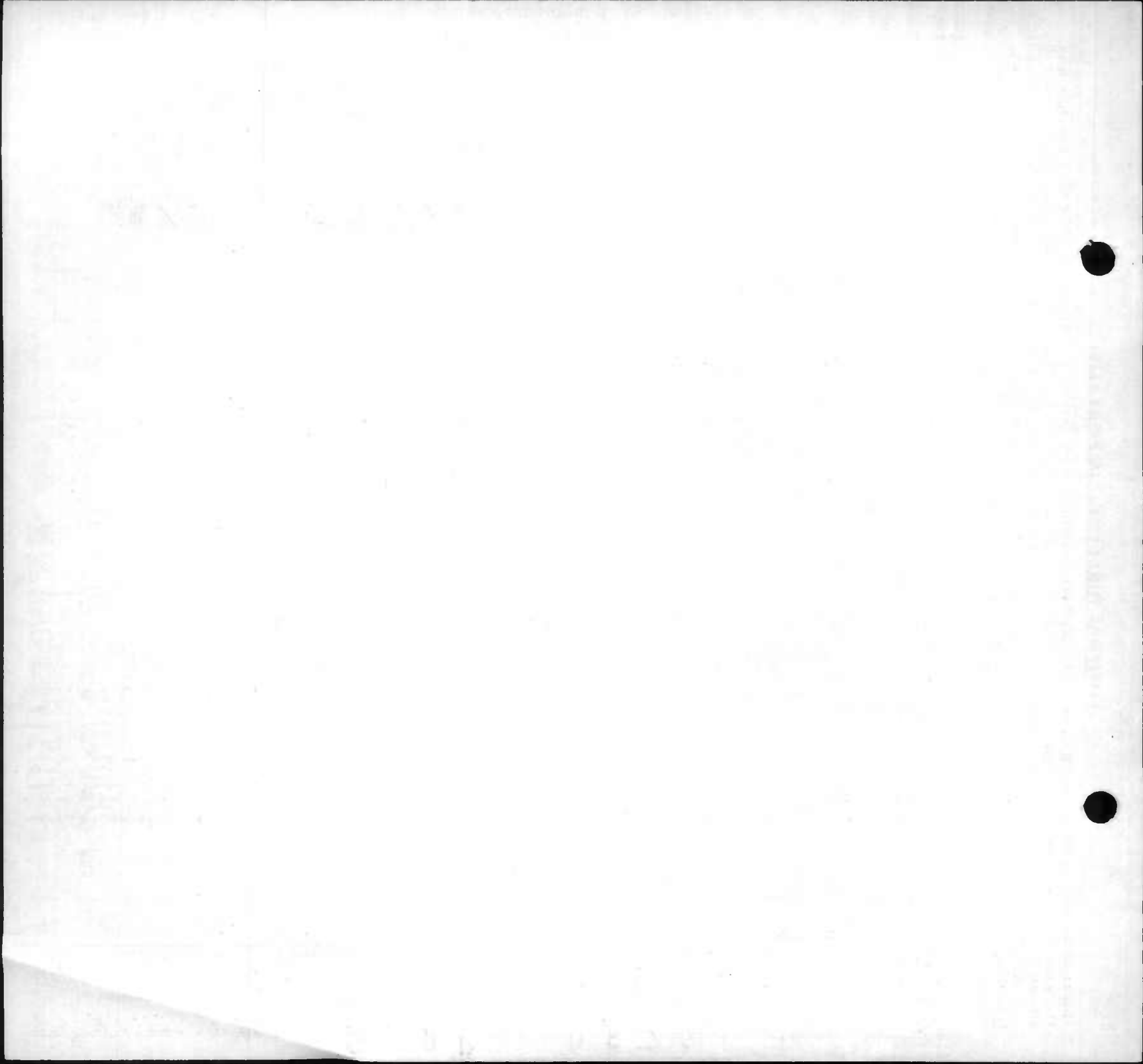




# FUNERAL DIRECTOR: IMPORTANT

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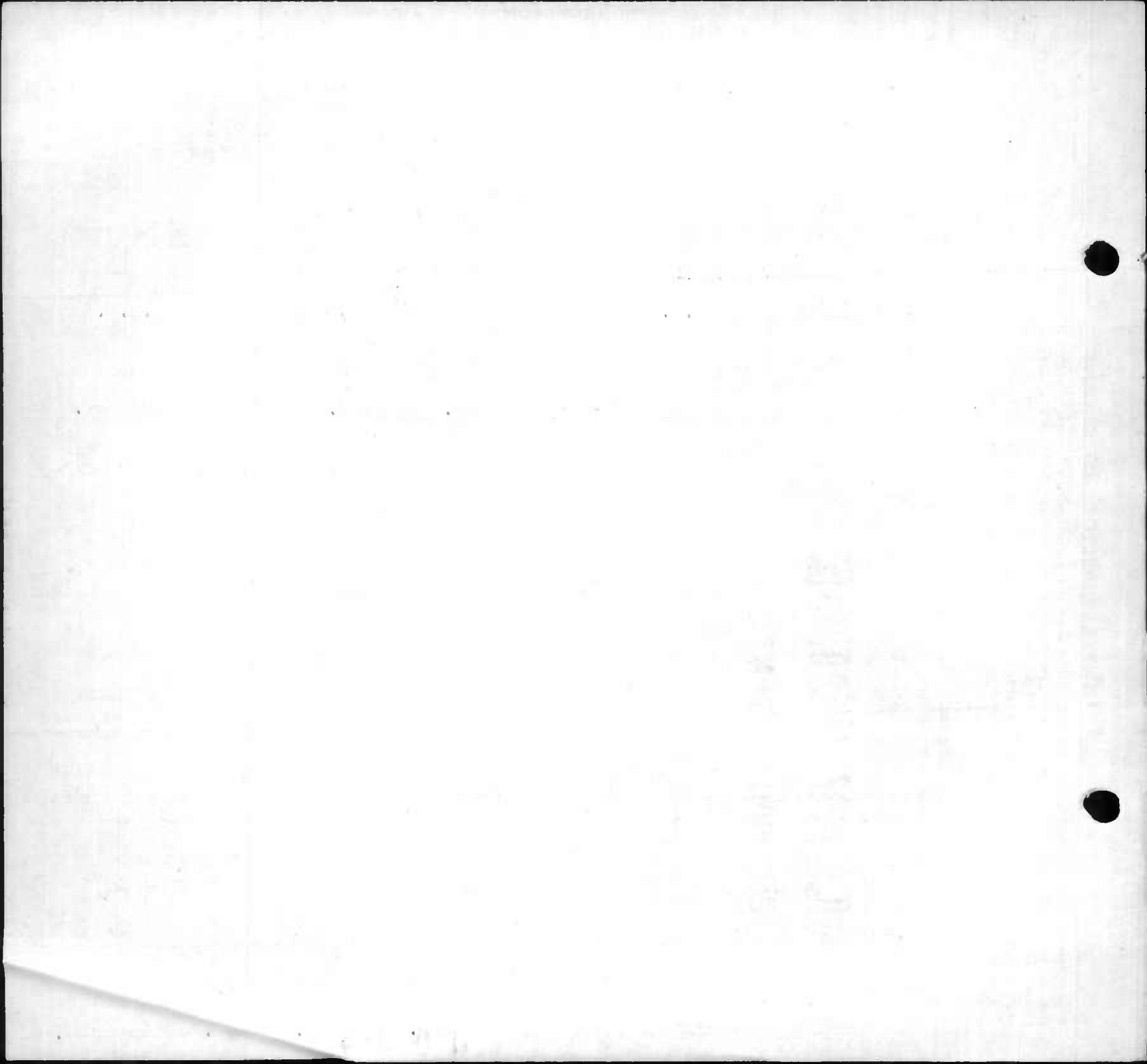
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4797</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4797</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ALASCIO, SAMUEL</span>			
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4 MAY, 1965 1:55 P.M.</span>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">M.D.</span> B. COUNTY <span style="font-size: 1.2em;">20-01</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">University Hospital</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTO.</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">577 ALDENISON ST</span>			
5. SEX <span style="font-size: 1.2em;">M.</span>	6. RACE <span style="font-size: 1.2em;">W.</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/10/1883</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">81</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ITALY</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">ITALY</span>					
13. FATHER'S NAME <span style="font-size: 1.2em;">GIUSEPPE ALASCIO</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">FRANCES GEPPI</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">216-01-4981</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MARY ALASCIO 577 N. DENISON ST</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CARDIAC FAILURE 48 HRS.</span>				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">8 HRS.</span>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">MYOCARDIAL INFARCT.</span>					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">4-20-11</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">1</span>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4-27</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">5-4</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5-4</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">J. Ward Kurad</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">4 May 65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. Ward Kurad</span>				23D. ADDRESS <span style="font-size: 1.2em;">Univ. Hosp.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5-7-1965</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">NEW CATHEDRAL CEM</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MD</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 6 1965</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">WEBER FUNERAL HOME 5311 EDMONDSON AVE</span>			



FUNERAL DIRECTOR: IMPORTANT

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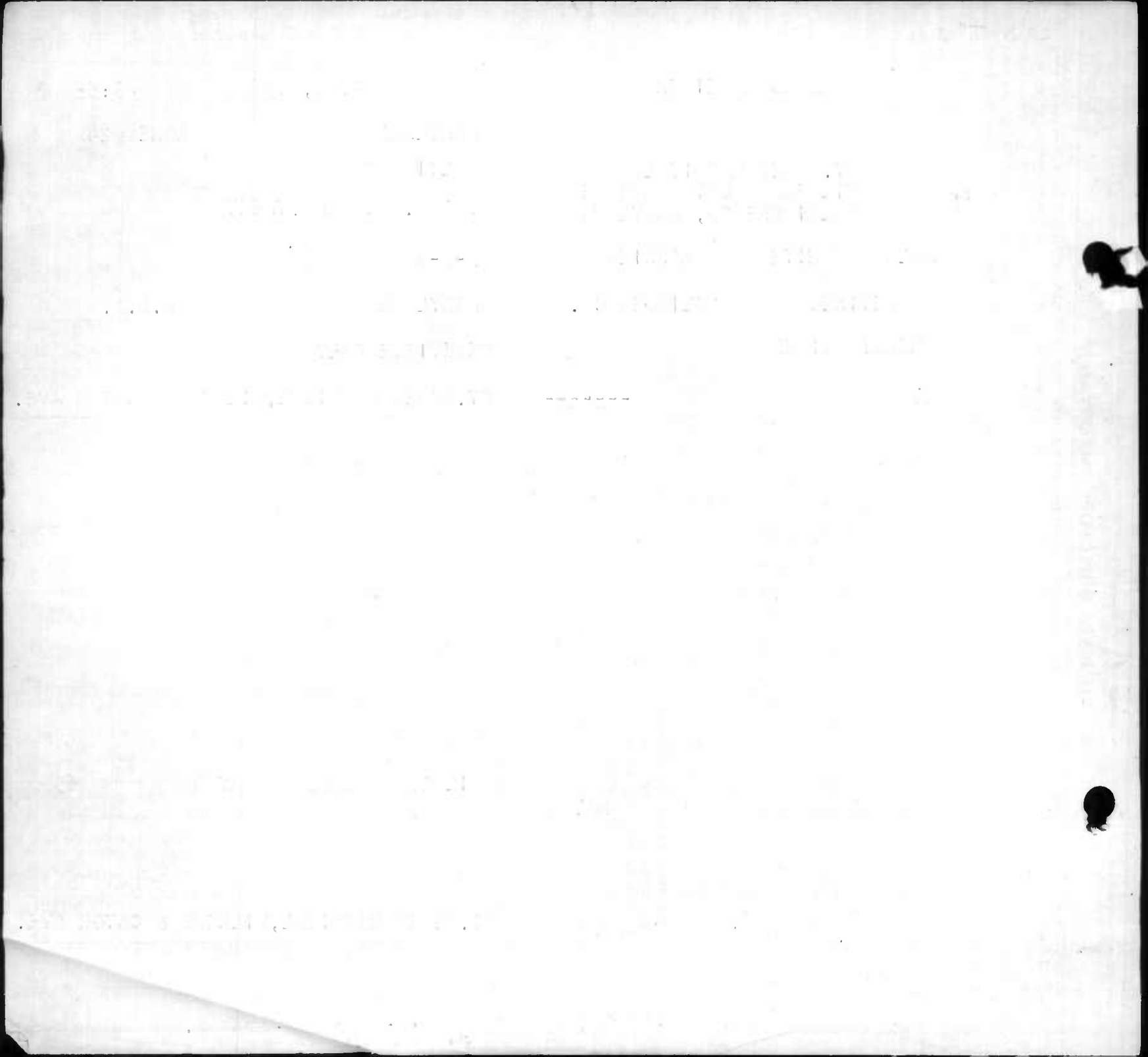
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4798</u>	
BIRTH NO. <u>65 4798</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Leo W. Flynn</u>		2. DATE AND HOUR OF DEATH <u>5/3/65</u> <u>11:30 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>26-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>5664 Karon Avenue</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>5664 Karon Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>4/10/1916</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>E. J. Dupont de Nemours</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Phillip Leo Flynn</u>		14. MOTHER'S MAIDEN NAME <u>Christine Spink</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>218-10-3640</u>		17. INFORMANT ADDRESS <u>Mrs. Evelyn M. Flynn 5644 Karon Ave.</u>	
18. <u>420.1 I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) <u>Acute Myocardial Infarction</u>			
ANTECEDENT CAUSES		(B) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 10</u> 19 <u>61</u> to <u>May 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>April 15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE <u>Albert J. Himelfarb</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/4/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALBERT J. HIMELFARB</u>		23D. ADDRESS <u>3501 ST. PAUL ST. BALTO MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/7/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1965</u>		25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>3000 E. Baltimore St.</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4799	
BIRTH NO. 65 4799				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>JOHN ADAM WEIDER</b>			2. DATE AND HOUR OF DEATH <b>MAY 4, 1965 3:55 PM.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE 29, MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ZONE #24</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>100 N. GLOVER STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-9-89</b>	9. AGE (In years last birthday) <b>76</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GLIDDEN CO.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY WEIDER</b>			14. MOTHER'S MAIDEN NAME <b>GENEVIEVE BALT Bultz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>274-03-6762</b>	17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>		
18. <b>433.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>abnormal arterio-sclerosis</b> <b>arterio-sclerosis C.V. disease</b>			CAUSE OF DEATH (A) <b>Hemiplegia, stroke -</b> DUE TO <b>Cerebral vessel.</b> (B) <b>Stroke</b> DUE TO (C) <b>arterio-sclerosis C.V. disease</b>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 27</b> 19 <b>65</b> to <b>MAY 4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>MAY 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>James H. Cernuschi</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/4/65</b>
23C. PHYSICIAN'S NAME (Type) <b>J.N. CANNOS M.D.</b>			23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Parbunod Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>		25B. NAME OF REGISTRAR <b>John A. Moran</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran Inc. 3000 E. Baltimore St</b>	



1

65 4800

BALTIMORE CITY HEALTH DEPARTMENT

65 4800

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPHINE M. GRIFFITH

DATE AND HOUR PRONOUNCED DEAD

April 4, 1965

6:15 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

125 N. Potomac St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

125 N. Potomac St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7/13/1880

9. AGE (In years  
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Shaller

14. MOTHER'S MAIDEN NAME

Anna P

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-18-0689

17. INFORMANT

Mr. Joseph Shaller 2406 Strathmore Ave.

ADDRESS

74

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-5-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/8/65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

John A. Moran, Inc. 3000 E. Balto. St.

ADDRESS

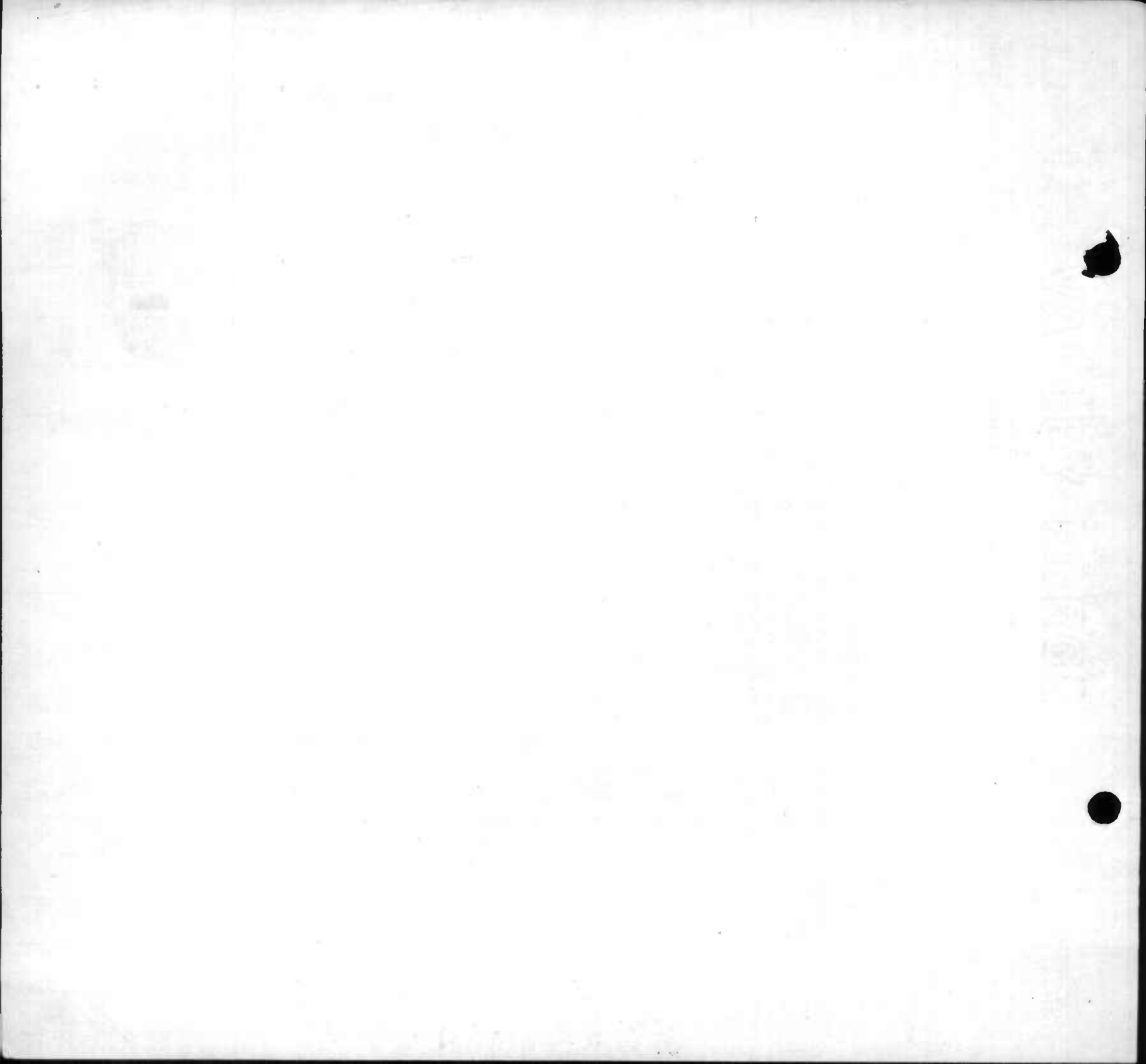
WALLLEY FORDS

HAS CONTENT



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

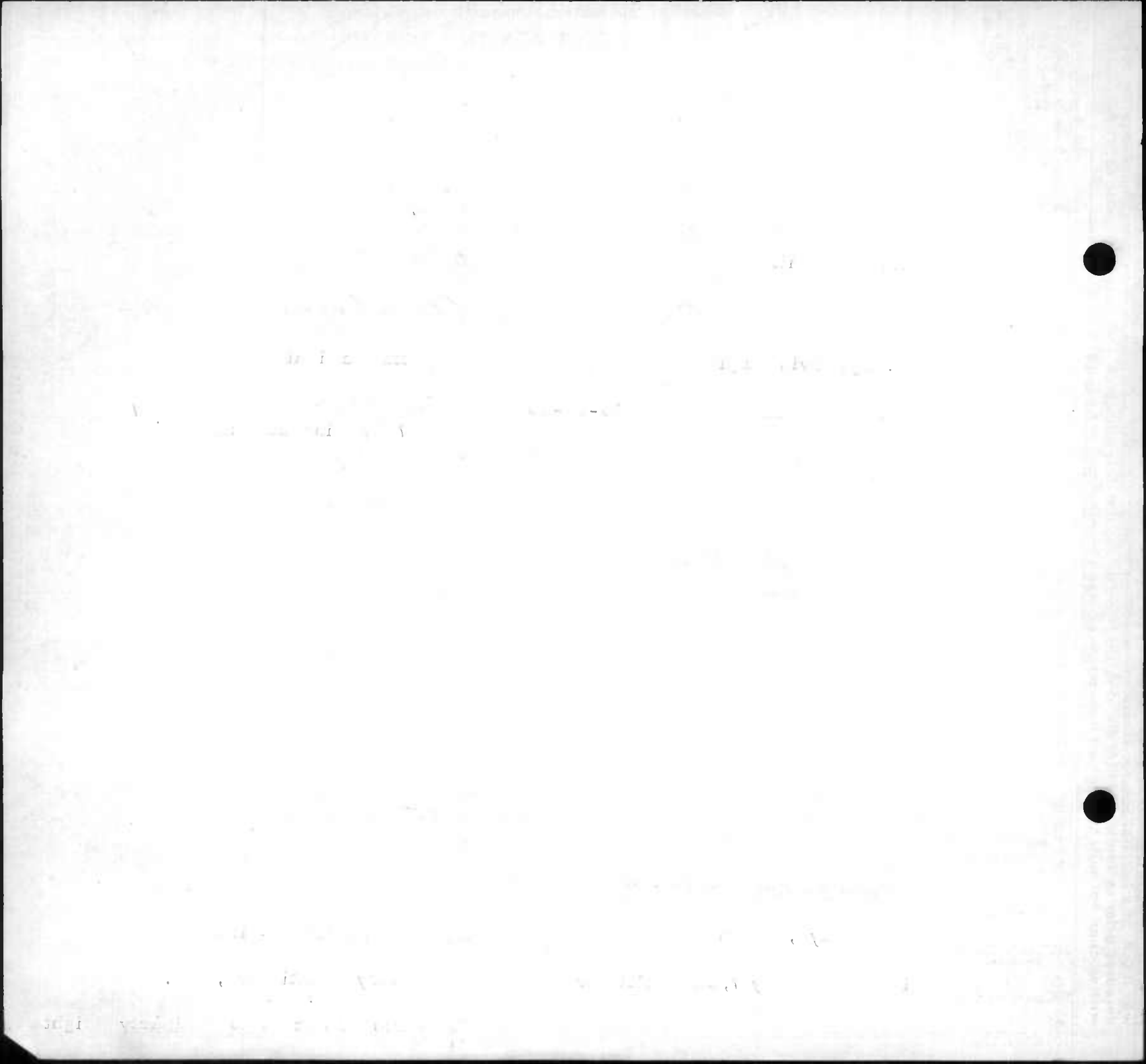
VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

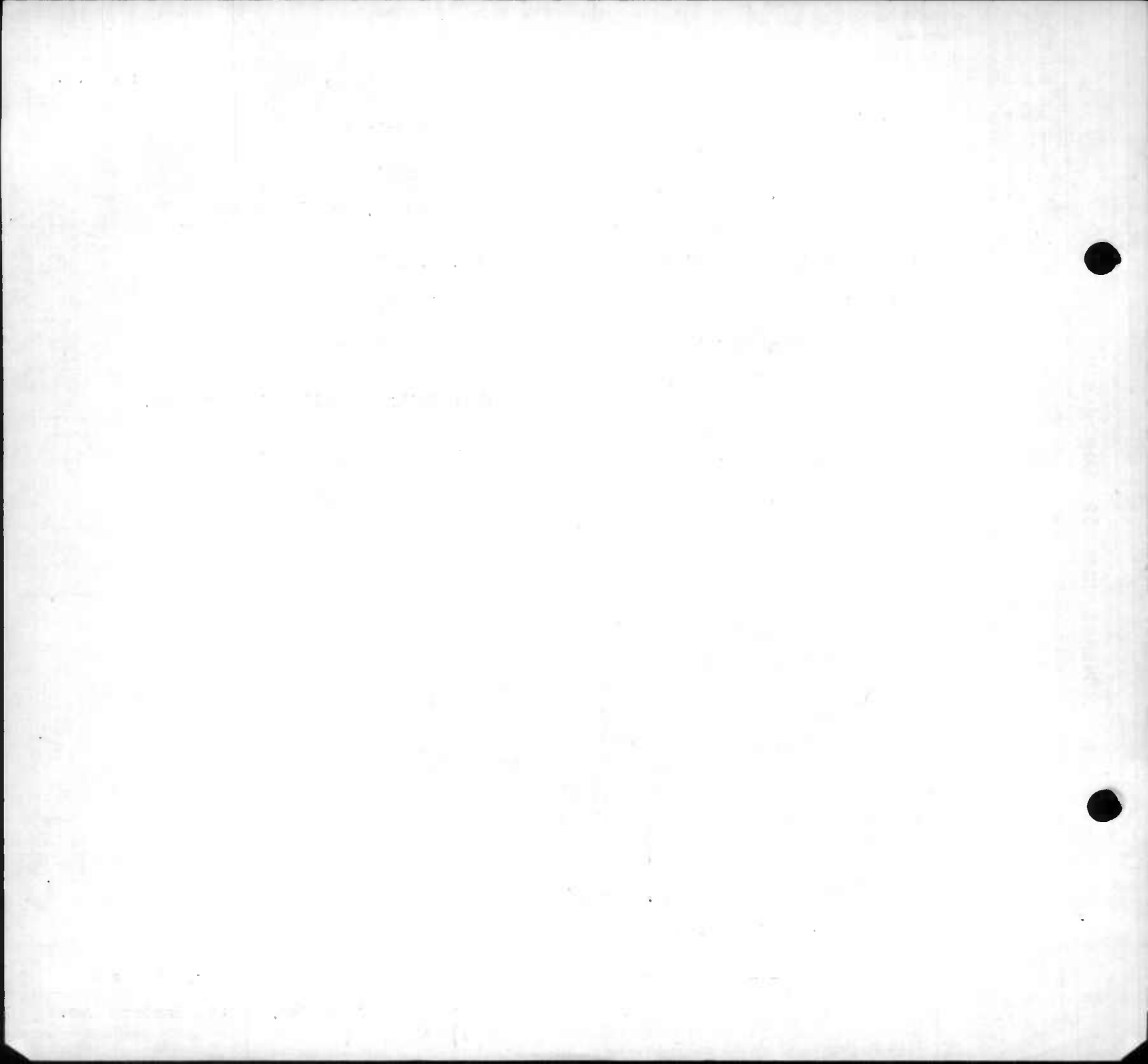
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4802				
BIRTH NO. 65 4802					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>WALTER G. HUGHES</b>					2. DATE AND HOUR OF DEATH <b>May 5, 1965 10:10 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland Gen. Hospital</b>					A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53.00</b>				
					D. STREET ADDRESS (If rural, give location) <b>7129 Windsor Mill Road</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify)	8. DATE OF BIRTH <b>12/11/03</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Majestic Distillery</b>		11. BIRTHPLACE (State or foreign country) <b>Panama Canal</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Irvin Hughes</b>					14. MOTHER'S MAIDEN NAME <b>Etta McGinnis</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>			16. SOCIAL SECURITY NO. <b>218-32-8614</b>		17. INFORMANT <b>Louise Hughes - same #7</b>			ADDRESS	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest &amp; Myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs. 20 min.</b>					CAUSE OF DEATH <b>7129 Windsor Mill Road</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>May 4 1965</b> to <b>May 5 1965</b> , that (I) (we) last saw the deceased alive on <b>12:20 A.M. 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Sabundayo, Rolando</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>May 5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Sabundayo, Rolando</b>					23D. ADDRESS M.D. <b>Maryland General Hospital</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 7, 65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATA REC'D BY HEALTH DEPT. <b>MAY 8 1965</b>					25B. NAME OF REGISTRAR <b>Ellsworth Armacost</b>				
					25C. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>				
					ADDRESS <b>4600 Liberty Heights</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

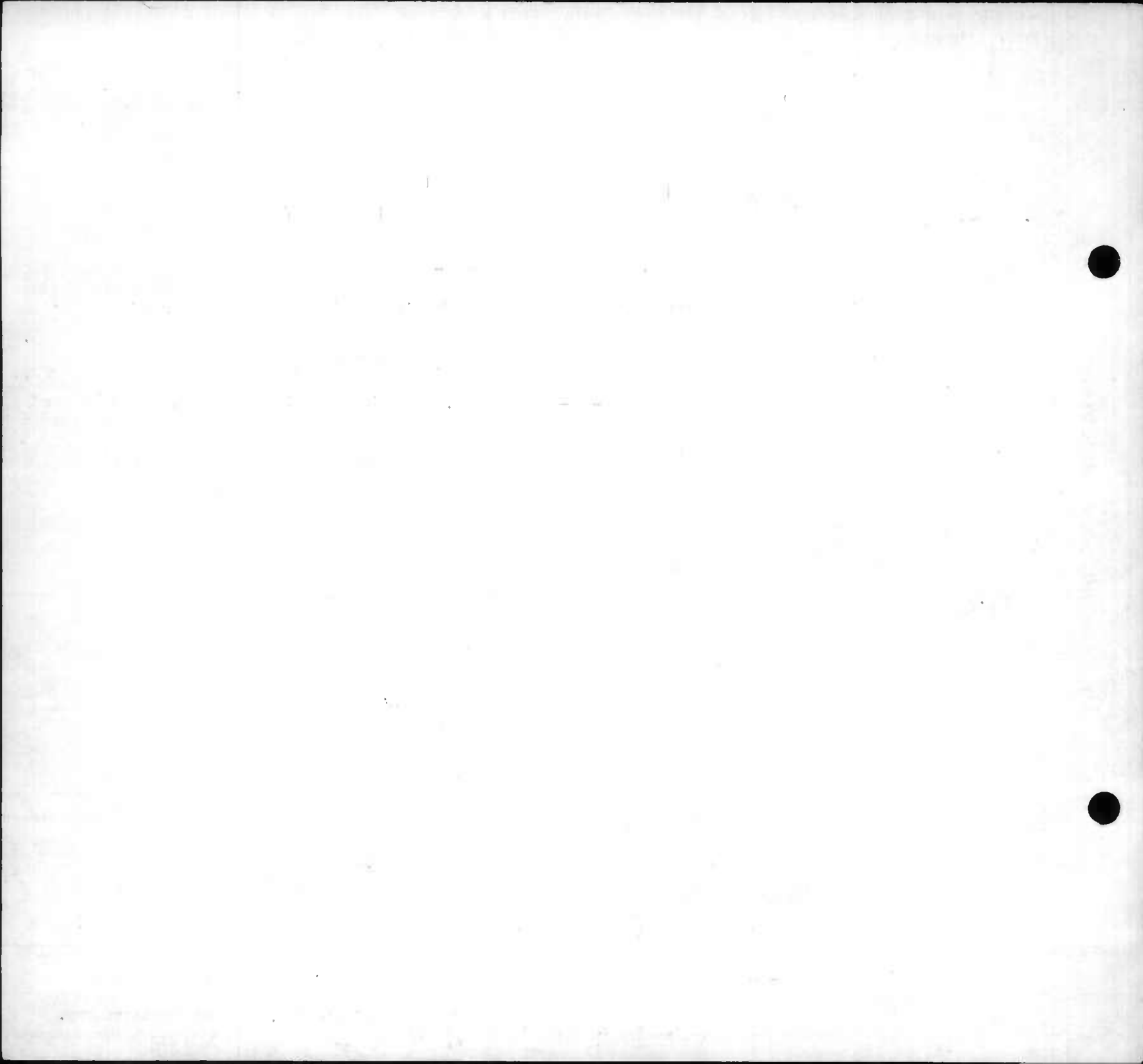
BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
M.E. CASE NO. 65 4803				CERTIFICATE OF DEATH				65 4803			
1. NAME OF DECEASED (Type or Print) ELIZABETH HULSEMAN				2. DATE AND HOUR OF DEATH May 3, 1965				9:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 501 S. Grundy Street				A. STATE Maryland				B. COUNTY 26-09			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore							
				D. STREET ADDRESS (If rural, give location) 501 S. Grundy Street							
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Oct. 8, 1877		9. AGE (In years last birthday) 87		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Frank Weinhold				14. MOTHER'S MAIDEN NAME Mary Adelman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT John Seitz			
								ADDRESS 3217 Clifmont Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Cerebral Accident (Stroke) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from January 1960 to 5/2 1965, that (I) last saw the deceased alive on 4/27 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Joseph R. Seitz M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5/5/65			
23C. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO M.D.				23D. ADDRESS 1508 BAYVIEW ST Baltimore 24, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-1965		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) Baltimore, County, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1965				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4804</b>	
BIRTH NO. <b>65 4804</b>				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH <b>5-4-65 1 230 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>REHME, ANNA</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
				D. STREET ADDRESS (If rural, give location) <b>346 HERRING COURT</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>2-14-87</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>
13. FATHER'S NAME <b>ALEXANDER Hoene</b>			14. MOTHER'S MAIDEN NAME <b>ELIZABETH Nestadek</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-24-4098</b>		
			17. INFORMANT <b>Mrs. Genevieve Tutin</b> ADDRESS <b>8418 Sandy Plain Road</b>		
18. <b>420.1 I</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute MI</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>2x6</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> 19 <b>65</b> to <b>5-4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5-4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bruce Lee Evans</i>				23B. DATE SIGNED <b>5-4-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>BRUCE LEE EVANS M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-6-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart</b>	
24D. LOCATION <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965 Robert E. Taylor</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>			





1

65 4805

BALTIMORE CITY HEALTH DEPARTMENT

65 4805

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JULIA JACKSON (Groomer)

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1965

1:20 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1419 N. Fulton Avenue

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3/9/90

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ephriam Gibson

14. MOTHER'S MAIDEN NAME

Cythian Parks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Brooks 2701 Westwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

# WALLLEY FONGLE

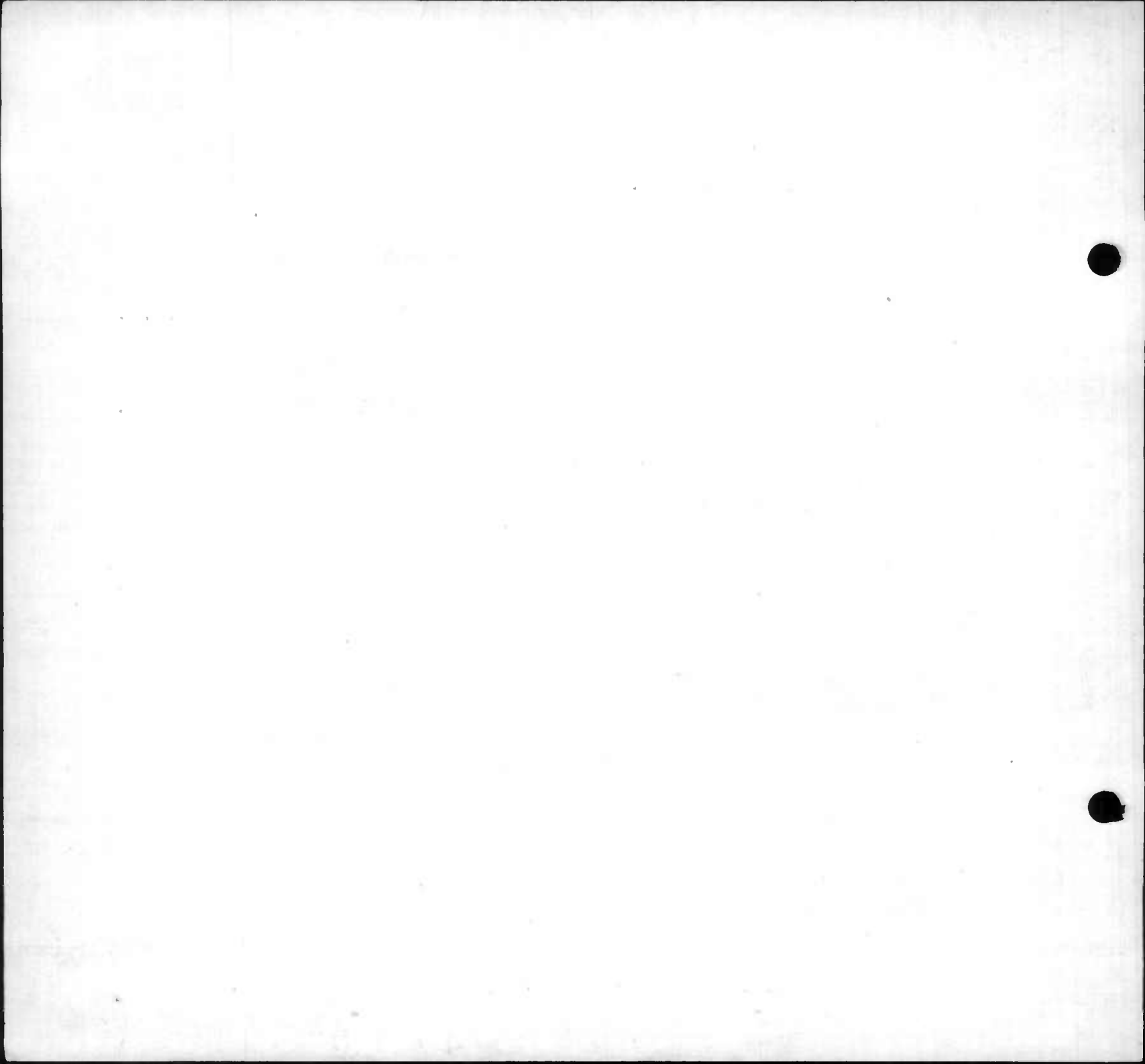
MAJESTIC

Left at 10:00 AM for  
Lafayette, Mich.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4806	
BIRTH NO. 65 4806		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH 5-4-65 330 A.M.			
1. NAME OF DECEASED (Type or Print) ANNA LYLES		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 14-02			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 17 D. STREET ADDRESS (If rural, give location) 1710 MCCULLOH ST.			
5. SEX FEMALE	6. RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-24-09	9. AGE (In years last birthday) 55	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALEX DOUGLAS			
14. MOTHER'S MAIDEN NAME CHRISTINE BROOKS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robert Lyles 3317 Egerton Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 2 CVA INTERVAL BETWEEN ONSET AND DEATH few hrs		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Slow UGI bleed, severe anemia		19A. DATE OF OPERATION 2 None			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/3 1965 to 5/4 1965, that (I) (we) last saw the deceased alive on 5/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Kokko		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/4/65	
23C. PHYSICIAN'S NAME (Type) J. P. Kokko		23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-65		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem.	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1965			
25B. NAME OF REGISTRAR Robert E. Jankovic		25C. FUNERAL DIRECTOR George A. Klor 1348 N. Calton St			



## CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Susie Frances Reddick

2. DATE AND HOUR OF DEATH

5-3-1965

4:00P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4218 Evans Chapel Road zone 21211

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Married

8. DATE OF BIRTH

4-6-1903

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

John Young

14. MOTHER'S MAIDEN NAME

Susie Green

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue, 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenio, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Cerebrovascular Accident  
DUE TO

Arteriosclerosis, generalized

(B) DUE TO

Diabetes Mellitus

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

8 hours

20 years

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY (Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-19-19 65 to 5-3-19 65,  
that (I) (we) last saw the deceased alive on 5-3-19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-3-1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/7/65

24C. NAME OF CEMETERY or CREMATORY

Balto. Natl. Cem.

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

25B. NAME OF REGISTRAR

Robert E. Bailey

25C. FUNERAL DIRECTOR

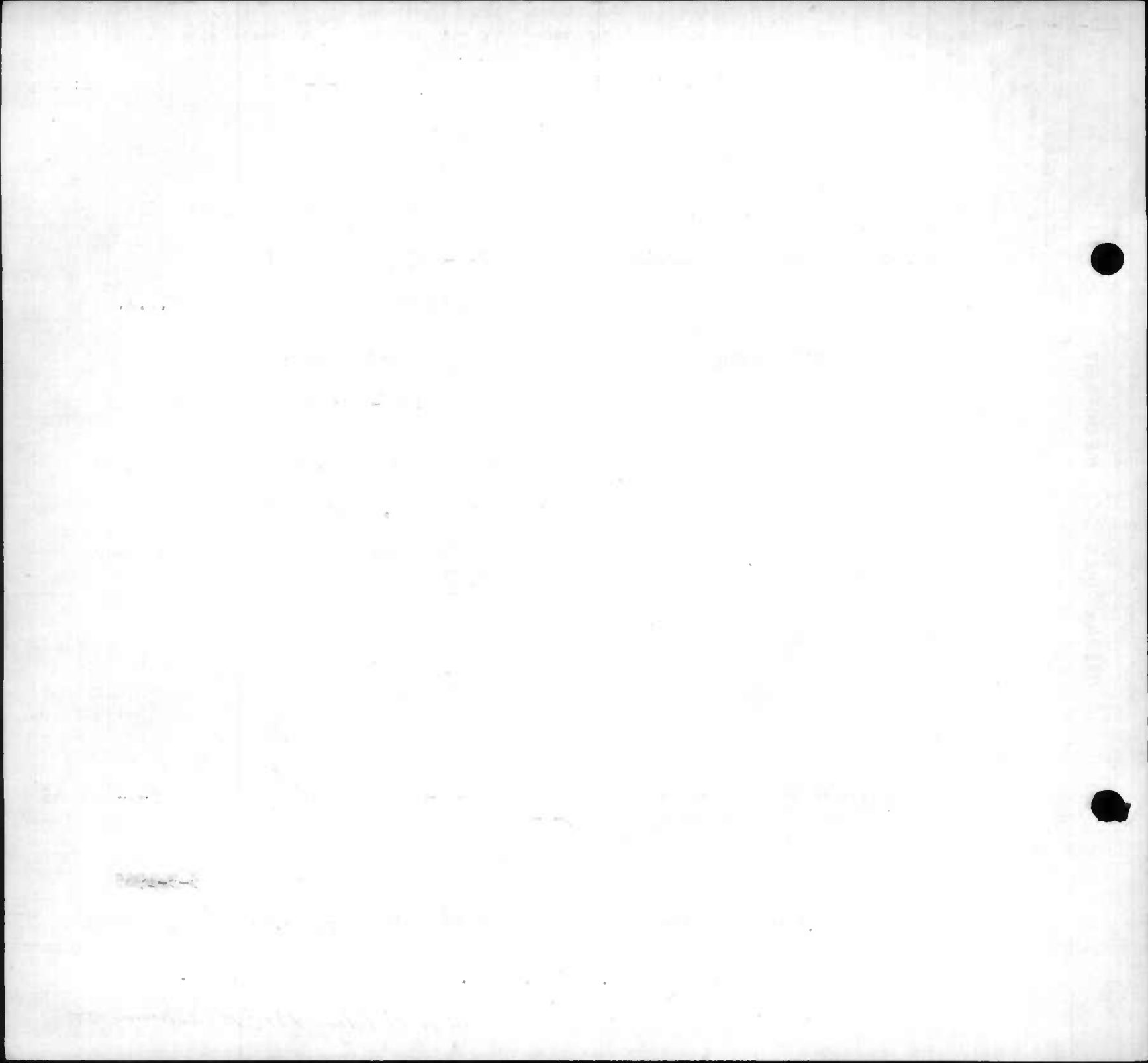
Spence H. Kiser

ADDRESS

1348 N. Calhoun St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4808	
CERTIFICATE OF DEATH											
BIRTH NO. 65 4808		M.E. CASE NO. 20015		1. NAME OF DECEASED (Type or Print) MORRIS GREENBERG				2. DATE AND HOUR OF DEATH 5-5-65 1 9 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEVINDALE HEBREW HOME AND INFIRMARY						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3400 WOODBINE AVENUE					
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED WIDOWED		8. DATE OF BIRTH 77		9. AGE (In years last birthday) 77		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCER				10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM J. GREENBERG						14. MOTHER'S MAIDEN NAME HANNAH R. ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT JOSEPH LEVINE & SON, PHILADELPHIA, PA.				ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 331X I BROINCHO PNEUMONIA CEREBROVASCULAR ACCIDENT GENERALIZED ARTERIOSELEROSIS POST CVA EPILEPSY										INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (a.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-14-1963 to 5-5-1965, that (I) (we) last saw the deceased alive on 5-5-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE CESAR VALLE CAVERO						M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED 5-5-65	
23C. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO						23D. ADDRESS LEVINDALE HEBREW HOME					
24A. BURIAL, CREMATION, REMAINS (Specify)		24B. DATE 5/6/65		24C. NAME OF CEMETERY or CREMATORY MONTIFIORE CEMETERY				24D. LOCATION (City, town, or county) (State) RXX PHILADELPHIA, PENNSYLVANIA			
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1965				25B. NAME OF REGISTRAR Sol Levinson				25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			

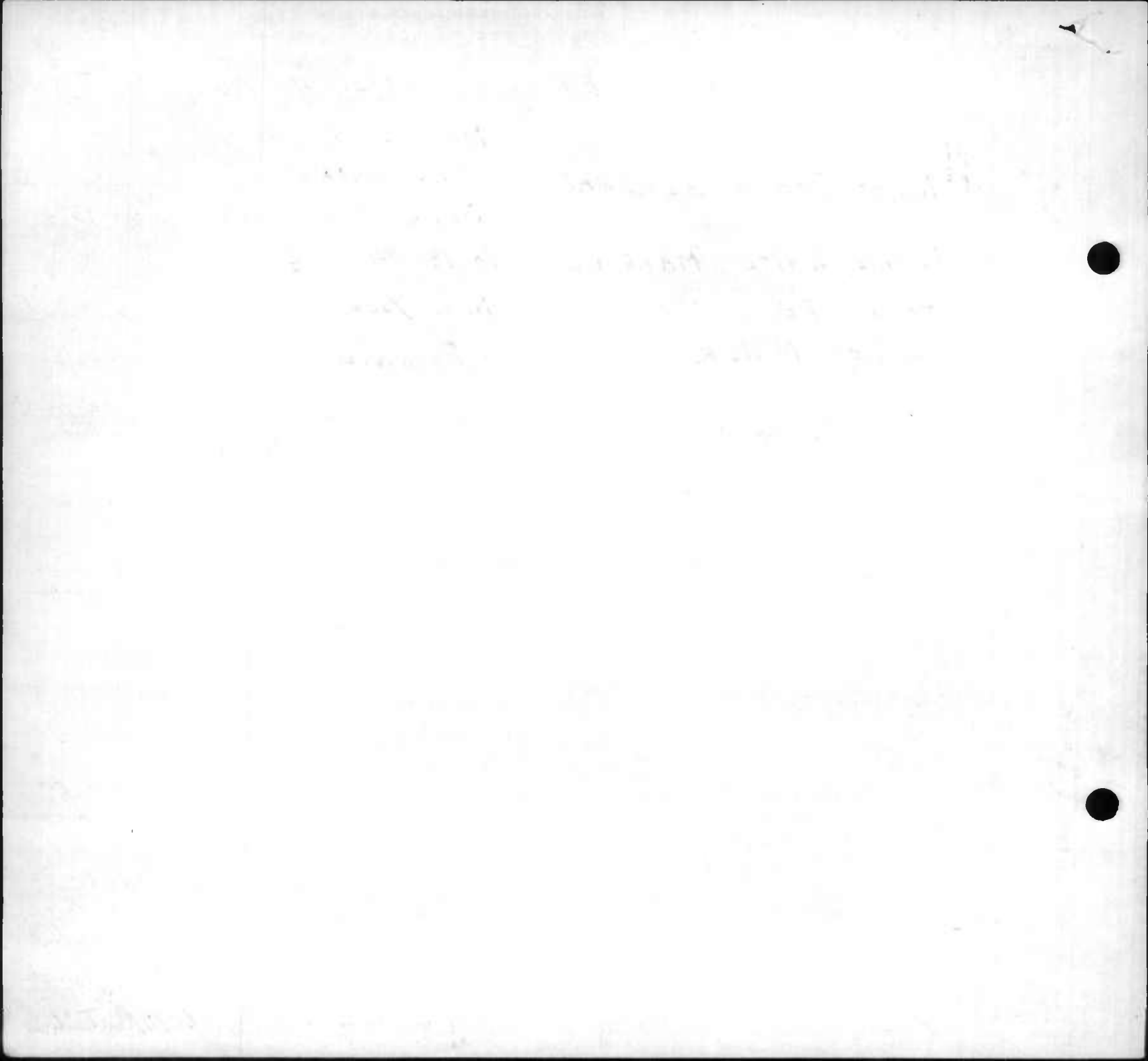




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

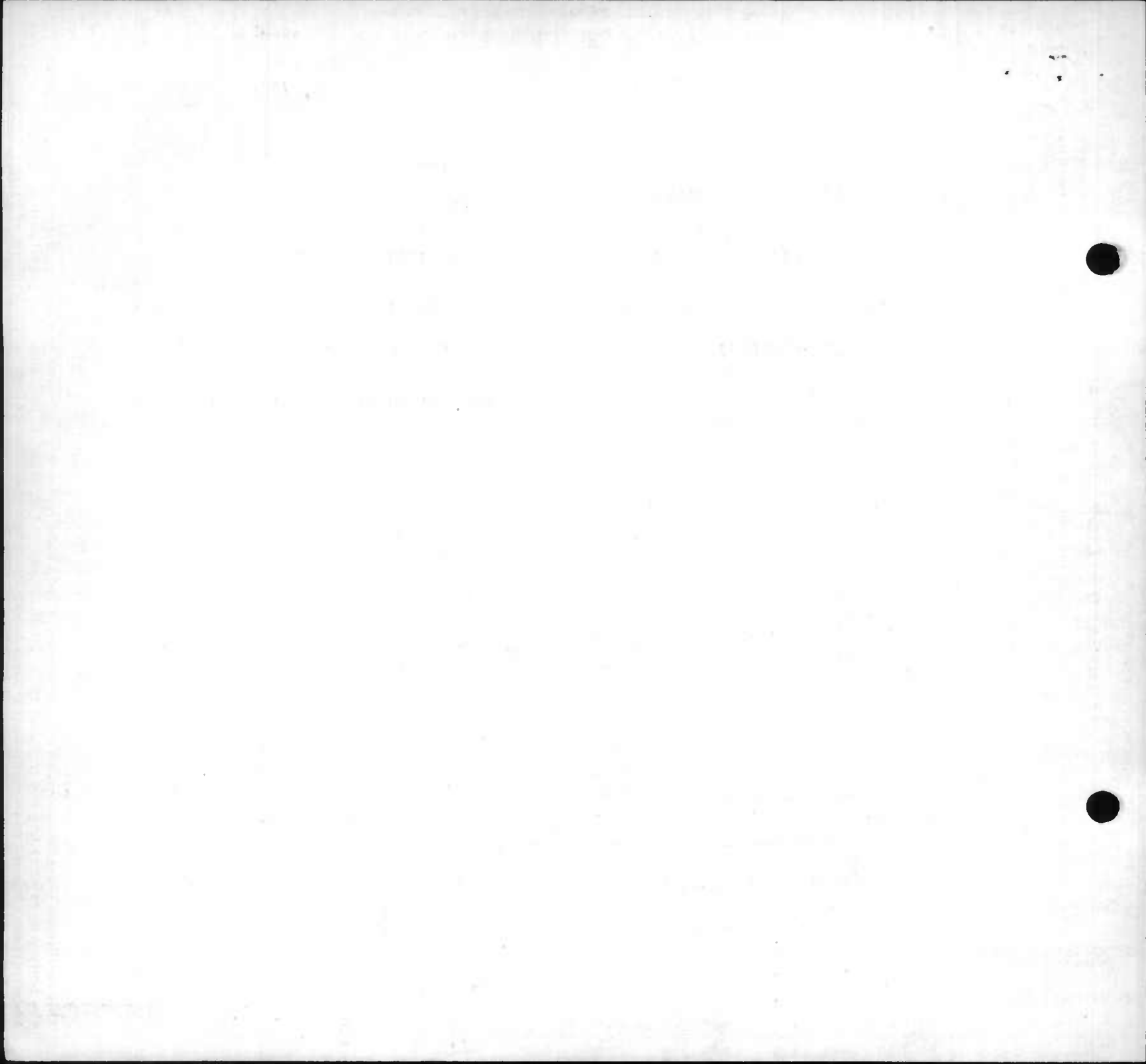
BIRTH NO.				CITY HEALTH DEPARTMENT		Registered No.	
M.E. CASE NO.				65 4809		65 4809	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ROSE MILLER MOFFET				MAY 4 1965 7 <sup>22</sup> A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
NORTH CHARLES GENERAL				MARYLAND 27-20			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTIMORE			
				D. STREET ADDRESS (If rural, give location)			
				3312 GLEN AVE ZONE 15			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
FEMALE	WHITE	MARRIED	10-18-04	60	HOUSEWIFE		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		
NEW YORK			AMERICAN U.S.A.		JULIUS MILLER		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
HATTIE SHAMOWITZ			NO				
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
NO			MR. MAX MOFFET 3312 Glen Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
153.8.1260X				Generalized metastatic			
ANTECEDENT CAUSES				DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				Carcinoma. Primary of			
				(C) DUE TO			
				Large bowel.			
II				Interval Between ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/28/65 19 to 5/4 1965, that (I) (we) last saw the deceased alive on 5/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
George Kehela						5/4/1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. A.A. Silver				M.D. Temple Garden Apt 2661 Madison Ave, Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/6/65		Hebrew Young Men		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 6 1965		Robert E. Farkas		J. Farkas		6010 Reisterstown	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

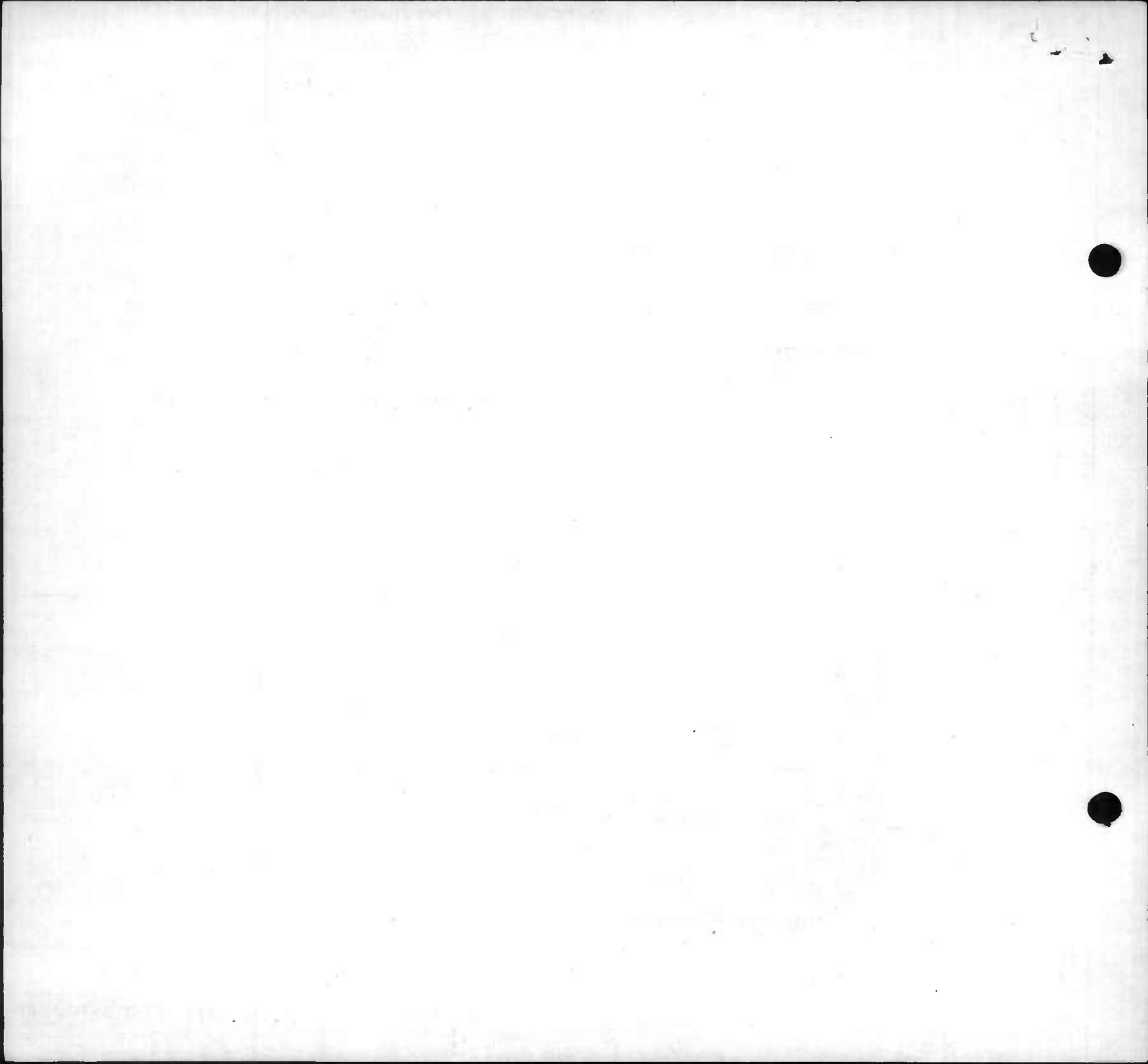
BALTIMORE CITY HEALTH DEPARTMENT									
65 4810 CERTIFICATE OF DEATH					Registered No. 65 4810				
1. NAME OF DECEASED (Type or Print) <b>JACOB SIEGEL</b>					2. DATE AND HOUR OF DEATH <b>MAY 5, 1965 12:30 A.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5108 NELSON AVENUE</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-18</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5108 NELSON AVENUE</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6/10/1891</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MENS CLOTHING</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>HARRY SIEGIL</b>					14. MOTHER'S MAIDEN NAME <b>TILLIE ?</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. SARAH SIEGEL 5108 NELSON AVE</b>				
18. <b>123X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Calcemia of Lung</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>None</b>					(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>None</b>					(B) DUE TO				
					(C) DUE TO				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>May 1</b> 19 <b>65</b> to <b>May 5</b> 19 <b>65</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>May 5</b> 19 <b>65</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <b>Manuel Levin</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/5/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN</b>					23D. ADDRESS <b>4818 Reisterstown Road</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

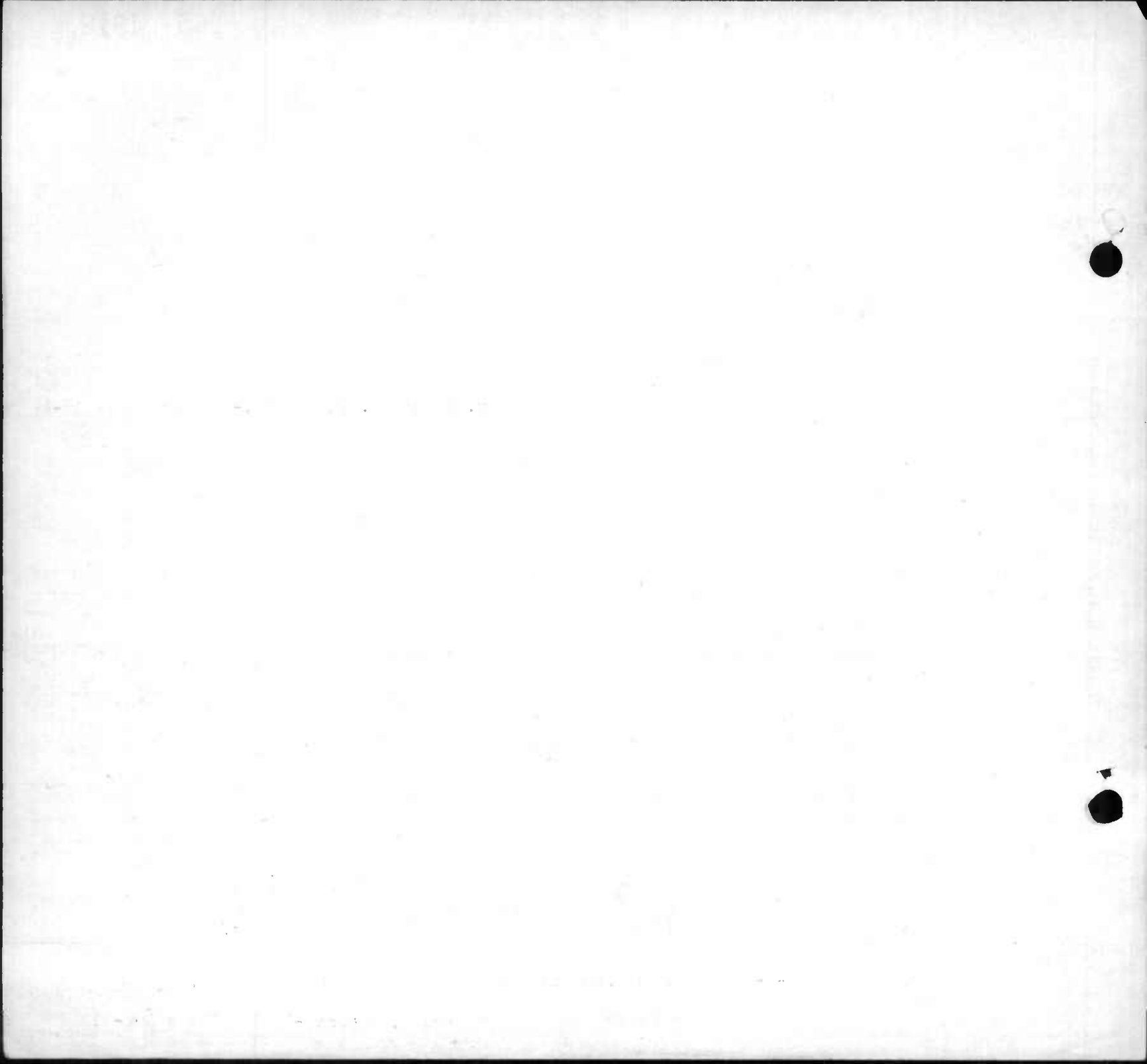
BALTIMORE CITY HEALTH DEPARTMENT										Registered No. 65 4811	
65 4811										65 4811	
BIRTH NO.										MAY 4, 1965	
M.E. CASE NO.										2 30 A.M.	
1. NAME OF DECEASED (Type or Print)										2. DATE AND HOUR OF DEATH	
IDA L. COHEN										MAY 4, 1965	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY	
3501 CLARKS LANE										MARYLAND	
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
										BALTIMORE	
										D. STREET ADDRESS (If rural, give location)	
										3501 CLARKS LANE	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
FEMALE		WHITE		MARRIED				61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
HOUSEWIFE				AT HOME				BALTIMORE, MARYLAND			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
MORRIS LEVINE						RACHEL ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO						NO		MR. MAX A. COHEN 3501 CLARKS LANE			
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
None								NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
NO											
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 4 MAY 65 19 to 9 MAY 65 19, that (I) (we) lost saw the deceased alive on 4 MAY 65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE										23B. DATE SIGNED	
MALCOLM S. DRUSKIN M.D.										4 May 65	
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS	
MALCOLM S. DRUSKIN										2217 SOUTH ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
BURIAL		5/5/65		HEBREW FRIENDSHIP				BALTIMORE MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
MAY 6 1965				Sol E. Fisher, M.D.				SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 4812</u>	
BIRTH NO. <u>65-11427 65 4812</u>				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>Boy Fricke</u>				2. DATE AND HOUR OF DEATH <u>5-4-65</u> <u>11:30</u> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore Md.</u> D. STREET ADDRESS (If rural, give location) <u>3823 Patapsco Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>INFANT</u>		8. DATE OF BIRTH <u>5-2-65</u>	9. AGE (In years last birthday) <u>2</u>	If Under 1 Yr. Months: Days: Hours: Min. <u>2</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Victor G Fricke</u>				14. MOTHER'S MAIDEN NAME <u>Beverly G. Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mr. Victor G. Fricke, Jr. - 3823 Patapsco Av-29</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>762.51 Atelectasis</u> <u>Prenatality</u>				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>N</u> (this hospital) attended the deceased from <u>5-2</u> 19 <u>65</u> to <u>5-4</u> 19 <u>65</u> , that <u>N</u> (we) last saw the deceased alive on <u>5-4-</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Op C Linantud, Jr.</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-4-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>CRISPIN C. LINANTUD, JR.</u>				23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-6-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fricke</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave-21229</u>	





BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 4813

1. NAME OF DECEASED  
(Type or Print)

RAYMOND BRYANT

2. DATE AND HOUR PRONOUNCED DEAD

5-3-65

10:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MERCY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3118 Sollers Point Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Nov. 16, 1915

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

House Painter

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Bryant

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ramona Cutbirth-3118 Sollers Pt. Rd

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) LOBAR PNEUMONIA  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Fatty metamorphosis of liver  
Partial

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 7-1965

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cem.

23D. LOCATION

(City, town, or county)

A. A. County

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Walkers Funeral Home - Pratt &amp; Stricker

ADDRESS

WALLEY POLICE

CHIEF OF POLICE

WALLEY, N.H.

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65

4814

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

4814

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EVA SAUERS

2. DATE AND HOUR PRONOUNCED DEAD

May 1, 1965

8:40 p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hoospital  
City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1207 Travers Way

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5-13-1900

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Inman. S. C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Becknell

14. MOTHER'S MAIDEN NAME

Elizabeth Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

219-05-5656

17. INFORMANT

ADDRESS

Husband as above

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5-1-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-5-65

23C. NAME of CEMETERY or CREMATORY

Sacred Heart Of Jeasus

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

Walter Dabrowski 1005 Dundalk Ave

MAILING PROGRAM

RECEIVED

NOV 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 4815		65 4815		65 4815	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SMART, Edward Francis		5-4-1965 12:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
UNION MEMORIAL HOSPITAL			Md. City of BALTIMORE		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore 13-09		
			D. STREET ADDRESS (If rural, give location)		
			848 WEST 36th Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	WH.	NEVER MARRIED	9/14/1919	45	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NEVER WORKED		—		BALTIMORE, Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Edward Francis SMART			MAUDE EMMA KAYSE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				MR. HARRY T. Smart, 1328 BERRY ST. # 11	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) metastatic Adenocarcinoma 6 mos. DUE TO (B) primary site unknown DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/28/65		ly-node biopsy		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-26-1965 to 5-4-1965, that (I) lost saw the deceased alive on 5-4-1965 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Peter F. Verkouw</i>				23B. DATE SIGNED 5/4/65	
23C. PHYSICIAN'S NAME (Type) PETER F. VERKOUW				23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/7/65		Baltimore National Cem.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1965		25B. NAME OF REGISTRAR Robert E. Barker		25C. FUNERAL DIRECTOR Walter Edward Home Proctor & Stricker	

U. S. DEPARTMENT OF JUSTICE

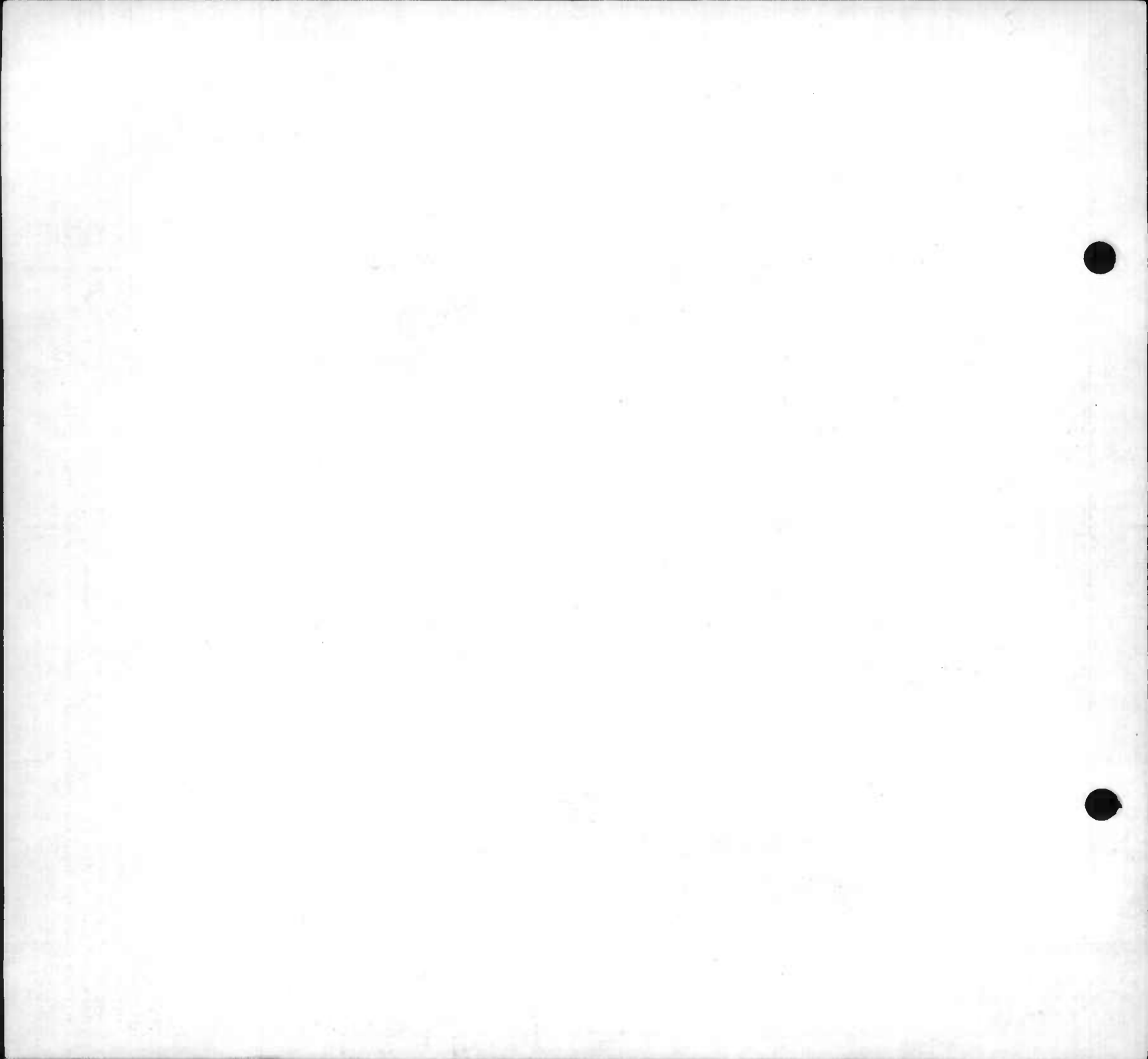
F. B. I.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4816		Baltimore City Health Department		Registered No. 65 4816	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>Earl Howard Owings</b>			2. DATE AND HOUR OF DEATH <b>5-1-65</b> <b>7:20 A</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> 8. COUNTY <b>26-03</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Hospital For the Women of Md.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>3682 Penyon Ave</b>					
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10-11-90</b>	9. AGE (If years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PENAL INSTITUTION</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. IZ.</b>		13. FATHER'S NAME <b>Milton (unkn) Owings</b>			
14. MOTHER'S MAIDEN NAME <b>unknown Rosa Bell Crooks</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>			
16. SOCIAL SECURITY NO. <b>217-20-7827</b>		17. INFORMANT ADDRESS <b>Patients chart.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>Peritonitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-5 day</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ruptured Appendix</b>			<b>4-5 days.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pulmonary Atelectasis</b>					
19A. DATE OF OPERATION <b>5-1-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5-1-65</b> to <b>5-1-65</b> , that (I) (we) last saw the deceased alive on <b>5-1-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Angela A. Infante</b>				23B. DATE SIGNED <b>5-1-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANGELITA DPACIO</b>		23D. ADDRESS M.D. <b>WOMEN'S HOSPITAL PACO-17, MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-4-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. OLIVE CEMETERY</b>	
24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>Wm Cook Brooks</b>		25D. ADDRESS <b>1050 York Rd Towson</b>	





## CERTIFICATE OF DEATH

Registered No. 65 4817

BIRTH NO.

65 4817

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Barbara Fay Henard

2. DATE AND HOUR OF DEATH

May 2, 1965

8:35 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4940 Eastern Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

6-8-45

9. AGE (In years  
last birthday)

19

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Tennessee

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Albert Henard

14. MOTHER'S MAIDEN NAME

Cecile Ringley

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #24

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) \_\_\_\_\_  
DUE TO

Myoclonus Epilepsy

8 Years

ANTECEDENT CAUSES

(B) \_\_\_\_\_  
DUE TODISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from May 24, 19 61 to May 2, 19 65  
 that (I) (we) last saw the deceased alive on May 2, 19 65 and that in (my) (our) opinion death occurred on the date  
 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 2, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

24B. DATE

5/6/65

24C. NAME OF CEMETERY or CREMATORY

Good Shepherd

24D. LOCATION

(City, town, or county)

Ellicott City, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

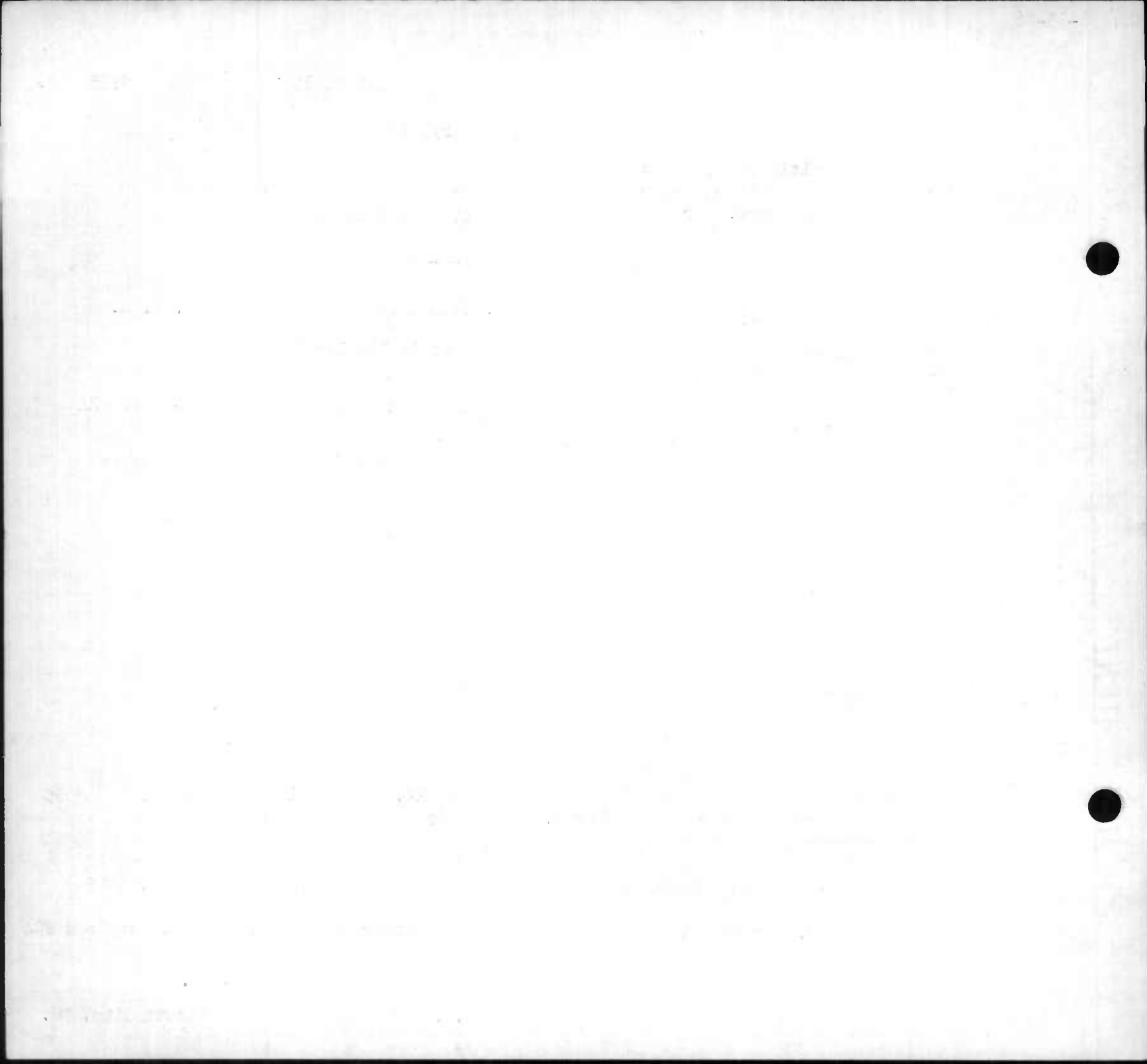
F.C. Higinbotham

ADDRESS

Ellicott City, Md.

FUNERAL DIRECTOR: IMPORTANT

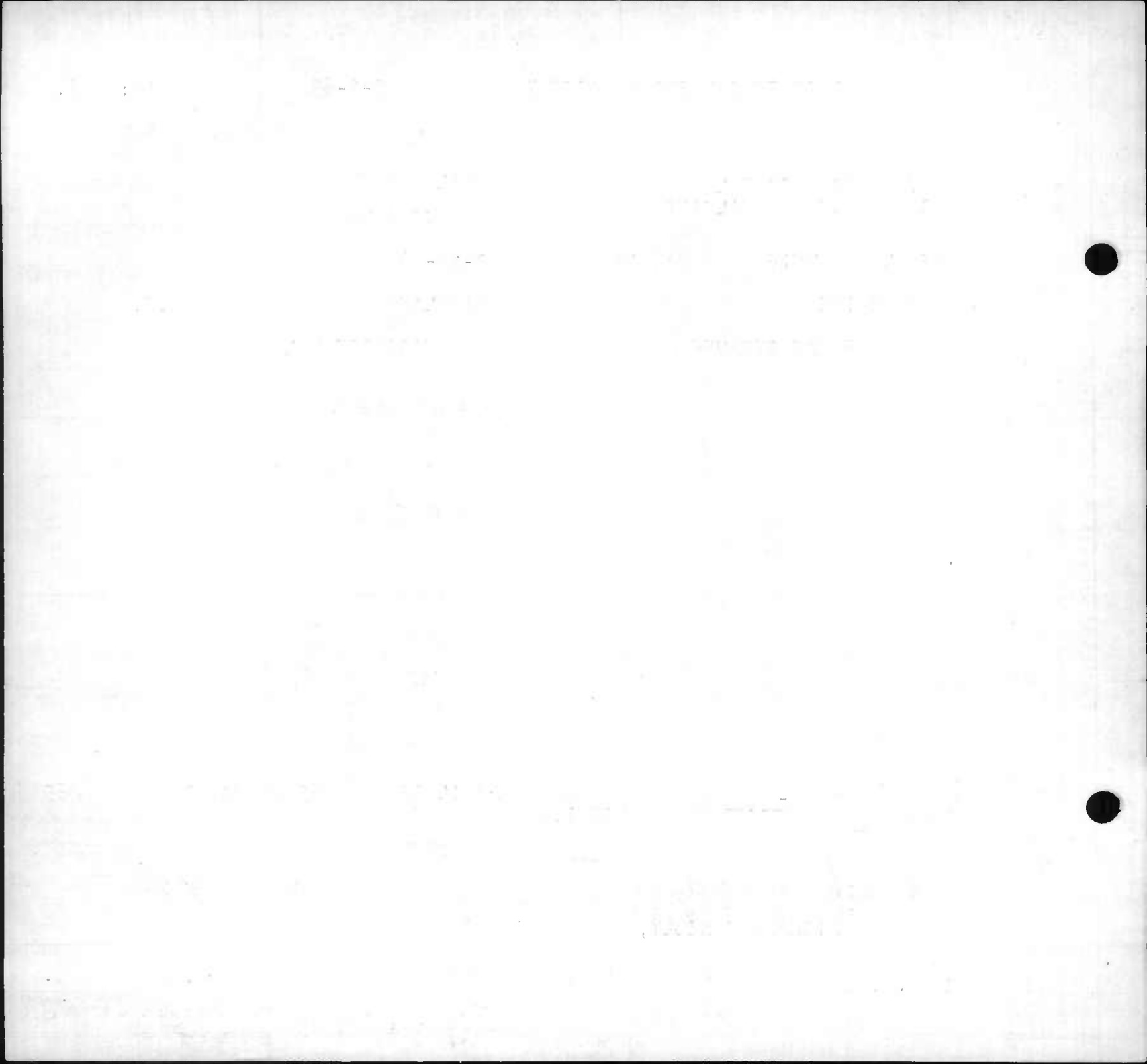
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

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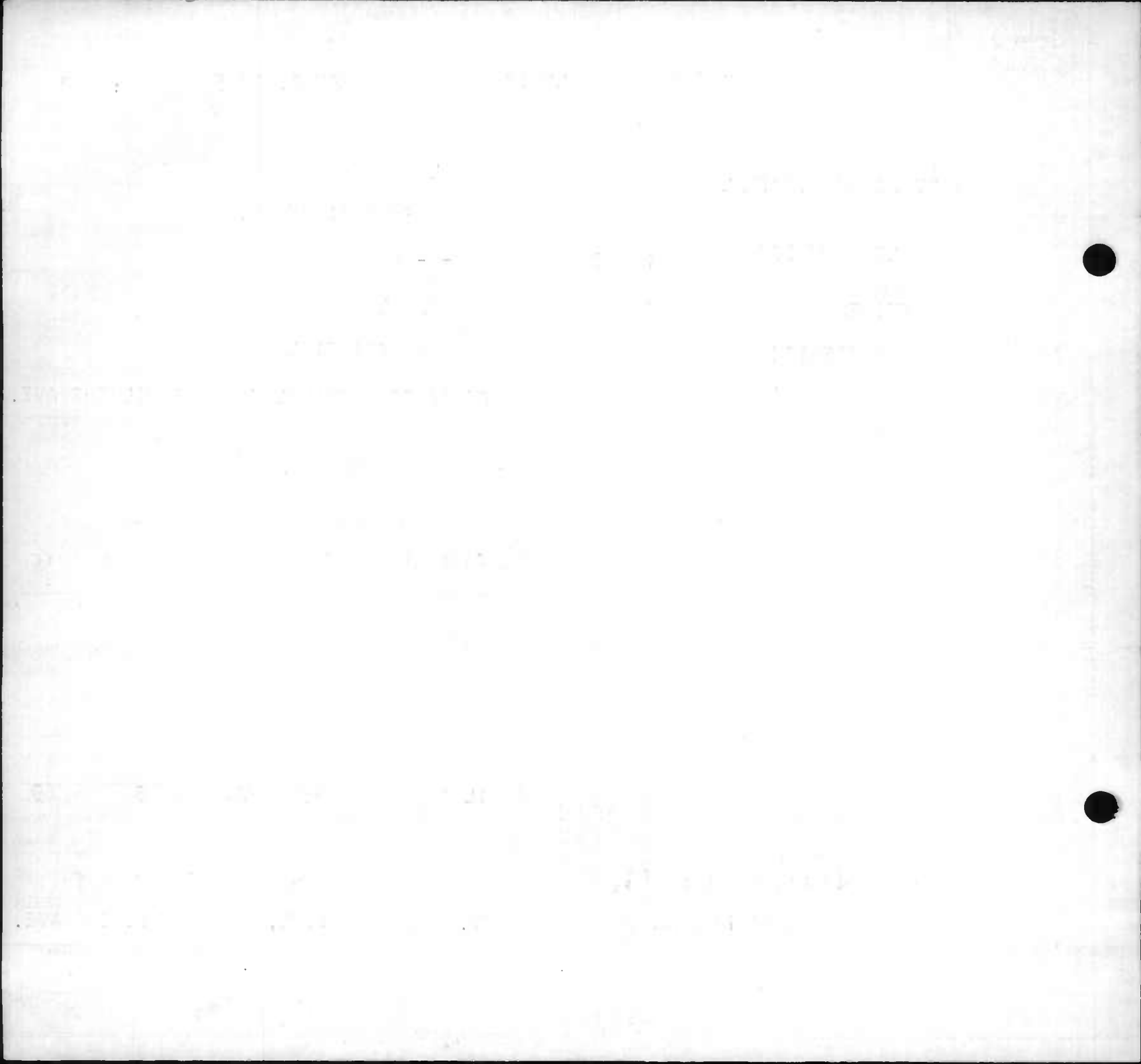
BALTIMORE CITY HEALTH DEPARTMENT				65 4818	
CERTIFICATE OF DEATH				Registered No. 65 4818	
BIRTH NO. 65 4818		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) MARGARET CATHERINE MACKERT			2. DATE AND HOUR OF DEATH 5-3-65 12:20 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON AVE AND WILKINS			A. STATE MARYLAND B. COUNTY BALTO. CO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 21228 53-00 16 CEDARWOOD ROAD		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 3-29-04	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HERMAN STRAUFF			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HOSP. REC.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I 170X CAUSE OF DEATH Carcinoma of Breast E Metastasis INTERVAL BETWEEN ONSET AND DEATH years					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 10 19 65 to MAY 3, 19 65, that (I) (we) last saw the deceased alive on MAY 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard J. Kelly M.D.				23B. DATE SIGNED 5/3/65	
23C. PHYSICIAN'S NAME (Type) RICHARD J KELLY,				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/6/65		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION BALTO. MD					
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR E. S. MAGNABB	
				ADDRESS 301 FREDERICK RD 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

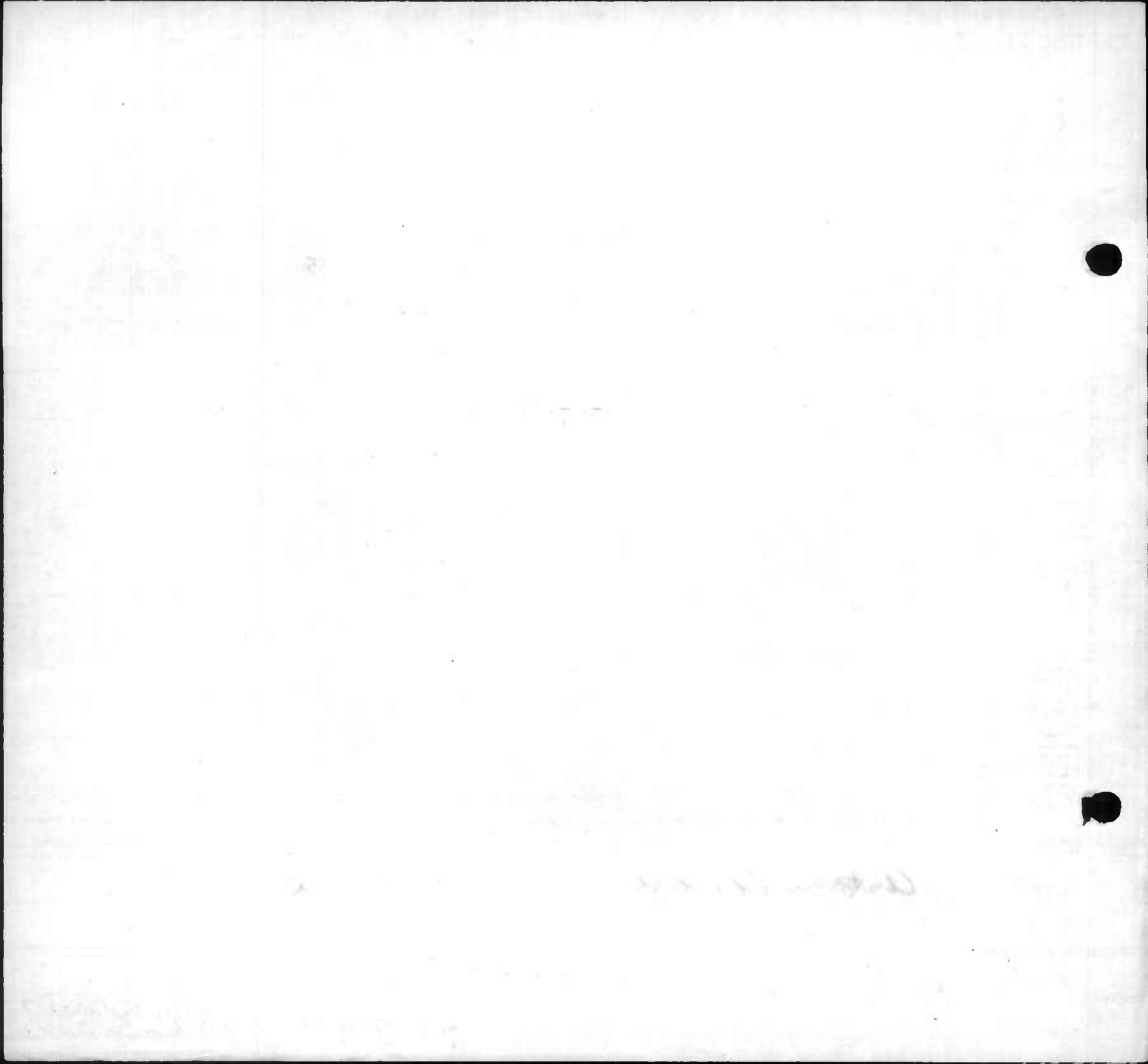
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4819</b>	
BIRTH NO. <b>65 4819</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>MUTHERT LOUIS</b>		2. DATE AND HOUR OF DEATH <b>MAY 3, 1965 12:10 P M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>829 SOUTHRIDGE RD.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10-2-73</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>FREDERICK</b>		14. MOTHER'S MAIDEN NAME <b>AGUSTA EINLOFF</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVE.</b>	
18. <b>5610 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Partial intestinal obstruction</b> INTERVAL BETWEEN ONSET AND DEATH <b>4-26-65 - 5-3-65</b>		CAUSE OF DEATH (A) <b>Partial intestinal obstruction</b> DUE TO (B) <b>Incarcerated Rt. inguinal hernia</b> DUE TO (C) <b>Anemia - (Polycystic Kidney Disease bilateral)</b> <b>4-26-65 - 5-3-65</b>		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>cardiac hypertrophy</b> <b>Polycystic kidney disease</b> <b>unknown</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4-29-1965</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Repair of Hernia</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 29</b> 19 <b>65</b> to <b>MAY 3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>MAY 3</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Arsenio Santos</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5. 3. 65.</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARSENIO SANTOS</b>		23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, CATON &amp; WILKENS AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>London Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Ave - Balto. Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Edgar M. ...</b>	
25D. ADDRESS <b>301 Frederick Rd - 18</b>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4820	
CERTIFICATE OF DEATH				Registered No. 65 4820	
BIRTH NO.		65 4820			
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Mr Jack Martin			5/3/65 7:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE Md		
Church Home & Hospital			B. COUNTY 6-05		
5. SEX Male			6. RACE white		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)			8. DATE OF BIRTH		
single			5/2/10		
9. AGE (in years last birthday)			10. AGE (in years last birthday)		
55			55		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
N.Y.			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Bob Martin			Lena		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			208-12-1247		
17. INFORMANT			ADDRESS		
Church Home & Hospital Records					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
Subarachnoid hemorrhage 2ry to			INTERVAL BETWEEN ONSET AND DEATH		
(A) DUE TO CVA			1 day		
(B) DUE TO Diabetes mellitus					
(C) DUE TO					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			Arteriosclerotic heart disease.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/23/65 19 to 5/3/65 19 that (I) (we) last saw the deceased alive on 5/3/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Antoine Arrage				23B. DATE SIGNED 5/5/65	
23C. PHYSICIAN'S NAME (Type) Antoine Arrage				23D. ADDRESS Church Home & hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/7/65		Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Baltimore Co., Md.		Baltimore Co., Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 6 1965		Robert E. Taylor		Wm. B. Johnson	
25D. ADDRESS		25E. ADDRESS			
Baltimore, Md. 21217		North Ave.			

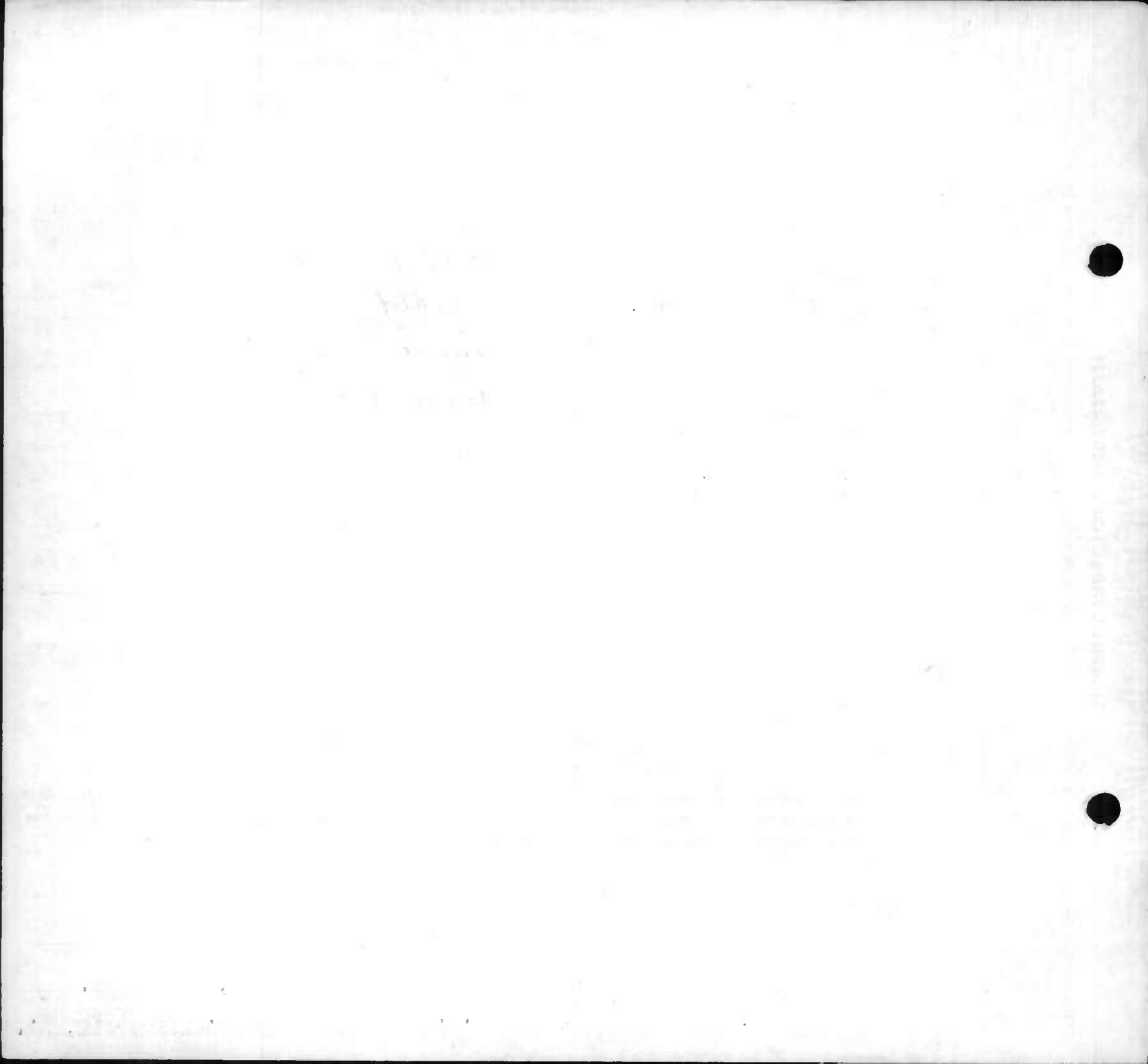




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

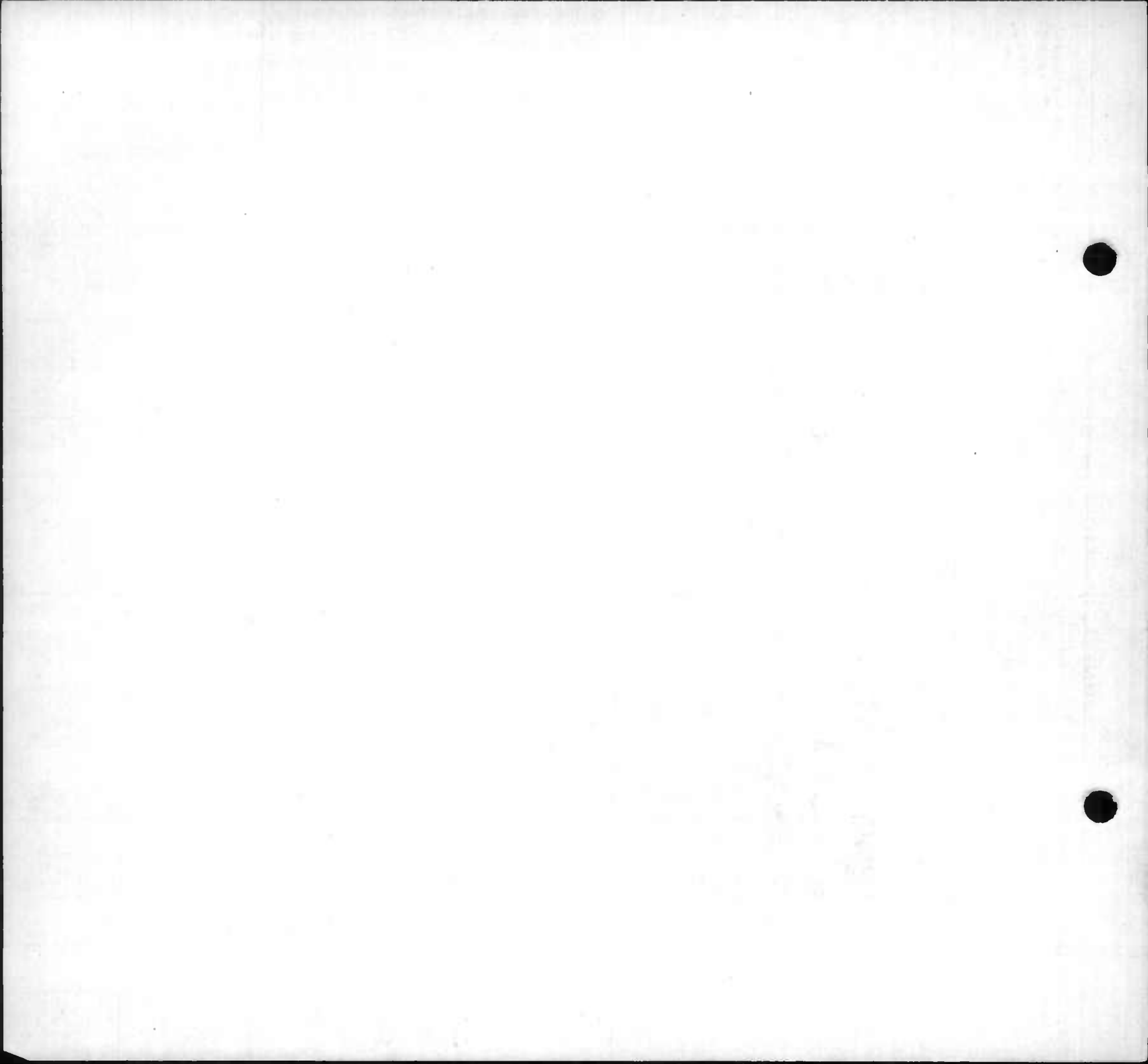
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4821</u>	
BIRTH NO. <u>65 4821</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>LACY, MARY AGNES GALVIN</u>	
2. DATE AND HOUR OF DEATH <u>May 4/65 8<sup>10</sup> AM</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-12</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u>			
6. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		7. STREET ADDRESS (If rural, give location) <u>6304 Glenburn Rd #12</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>M.</u>	8. DATE OF BIRTH <u>1/31/34</u>	9. AGE (In years last birthday) <u>31</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John P. Galvin</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Hying</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-32-5572</u>		17. INFORMANT <u>JOSEPH J. LACY</u> ADDRESS <u>(SAME)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of the Rt lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <u>metastases</u>		(B) DUE TO	
(C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>01-3-63</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer lung</u>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> 19 <u>65</u> to <u>May 5</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 5</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Amir H. Khazai</u> M.D.		23B. DATE SIGNED <u>May 4-1965</u>		23C. PHYSICIAN'S NAME (Type) <u>AMIR H. KHAZEI</u>	
23D. ADDRESS <u>University Hosp.</u> M.D.		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/7/1965</u>	
24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1965</u>	
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>		25D. ADDRESS <u>4905 York Rd. Baltimore 12, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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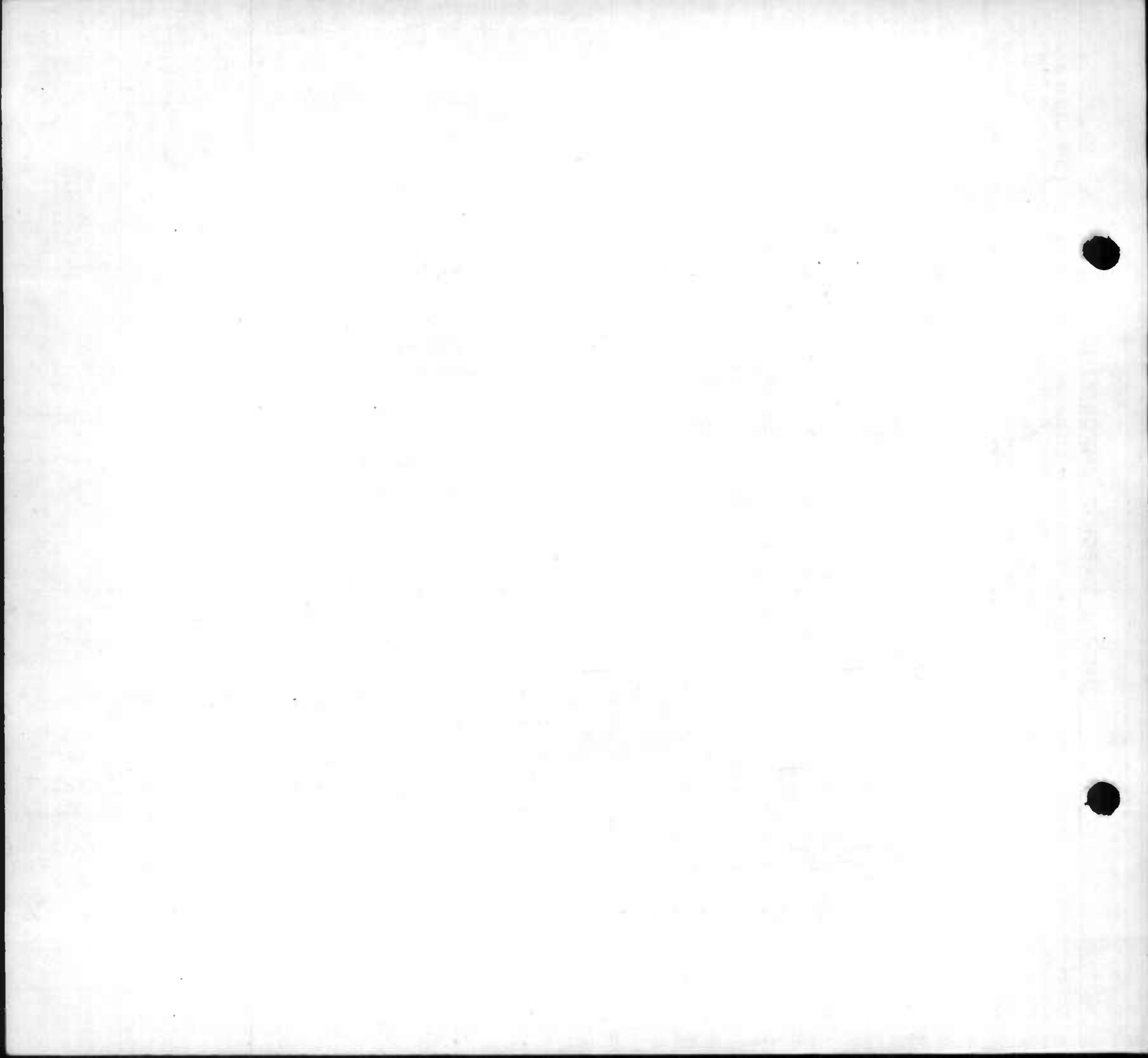
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4822</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4822</span>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<span style="font-size: 1.2em;">ARTHUR H. HERKLOTZ</span>		<span style="font-size: 1.2em;">MAY 4, 1965</span> <span style="float: right;">11:25P. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">1532 Upshire Road</span>			A. STATE <span style="float: right;"><span style="font-size: 1.2em;">9-02</span></span>		
			B. COUNTY <span style="float: right;"><span style="font-size: 1.2em;">Baltimore Maryland</span></span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			<span style="font-size: 1.2em;">Baltimore</span>		
			D. STREET ADDRESS (If rural, give location)		
			<span style="font-size: 1.2em;">1532 Upshire Road 21218</span>		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)
<span style="font-size: 1.2em;">Male</span>	<span style="font-size: 1.2em;">White</span>	<span style="font-size: 1.2em;">Married</span>		<span style="font-size: 1.2em;">Sept. 6, 1888</span>	<span style="font-size: 1.2em;">76</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<span style="font-size: 1.2em;">Gas Station Dealer</span>		<span style="font-size: 1.2em;">Retired</span>		<span style="font-size: 1.2em;">Baltimore Maryland</span>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<span style="font-size: 1.2em;">Henry Herklotz</span>			<span style="font-size: 1.2em;">Catherine Rupp</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<span style="font-size: 1.2em;">NO</span>		<span style="font-size: 1.2em;">214 03 4793</span>		<span style="font-size: 1.2em;">Mrs Madeline Herklotz 1532 Upshire RD</span>	
18. <span style="font-size: 1.2em;">420.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <span style="font-size: 1.2em;">Arterio sclerotic heart disease 5 yr</span>		
			(B) <span style="font-size: 1.2em;">DUE TO</span>		
			(C) <span style="font-size: 1.2em;">DUE TO</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<span style="font-size: 1.2em;">Rheumatoid arthritis 10 yr</span>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<span style="font-size: 1.2em;">none</span>		<span style="font-size: 1.2em;">none</span>		<span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
<span style="font-size: 1.2em;">no</span>		<span style="font-size: 1.2em;">no</span>		<span style="font-size: 1.2em;">no</span>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<span style="font-size: 1.2em;">none</span>		<span style="font-size: 1.2em;">no</span>		<span style="font-size: 1.2em;">no</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/1 1965</span> to <span style="font-size: 1.2em;">5/4 1965</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/1 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Manner Fildman</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/5/65</span>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				<span style="font-size: 1.2em;">2 E Read St.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">5/7/65</span>		<span style="font-size: 1.2em;">Glen Haven</span>	
				<span style="font-size: 1.2em;">Glenn Burnie Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<span style="font-size: 1.2em;">MAY 6 1965</span>		<span style="font-size: 1.2em;">Robert E. Fildman</span>		<span style="font-size: 1.2em;">Henry Sander &amp; Sons Inc.</span>	
				<span style="font-size: 1.2em;">Baltimore Maryland 21213</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 4823		REGISTERED NO. 65 4823	
CERTIFICATE OF DEATH							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				ERNESTINE WILHELMINA BIEGLER		MAY 3, 1965 12:48 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND		9-04	
Gould Convalesarium 6116 Belair Road				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
				D. STREET ADDRESS (If rural, give location)		2720 Matthews Street	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
F. W.		Widow	May 7, 1879	85			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Baltimore, Maryland		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Herman Gruenwald			Wilhelmina Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO			212 07 3792		9638 Oak Summit Avenue 21234 Mr John W. Fink Sr.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 14012.0				Arteriosclerotic Heart		not known	
ANTECEDENT CAUSES				(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Old Pott's Disease of spine			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 24 1964 to May 3 1965, that (I) (we) last saw the deceased alive on May 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
V. SADARANYA						5-5-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				6801 Belair Rd, Baltimore 6 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/7/65		Moreland Memorial Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
MAY 6 1965		Robert E. Fairbank		HENRY SANDER & SONS INC.			
				BALTIMORE, MARYLAND			



30-37-58 AM

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 4824

BIRTH NO.

65 4824

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Joe (Joseph) Fountain

2. DATE AND HOUR OF DEATH

5-4-65

8:25 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1909 Oak Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7-10-12

9. AGE (In years  
last birthday)

52

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Cleon Fountain

14. MOTHER'S MAIDEN NAME

-----

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

223-01-9786

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Seizures  
DUE TO

1 Month

ANTECEDENT CAUSES

(B) Cerebro Vascular Accident (L)  
DUE TODISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C) -----

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-11 19 65 to 5-4-65 19 65  
that (I) (we) last saw the deceased alive on 5-4- 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-4-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Philip Zieve

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/9/65

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

South Boston, Virginia

25A. DATE REC'D BY HEALTH DEPT.

MAY 8 1965

25B. NAME OF REGISTRAR

Robert E. Fulkerson

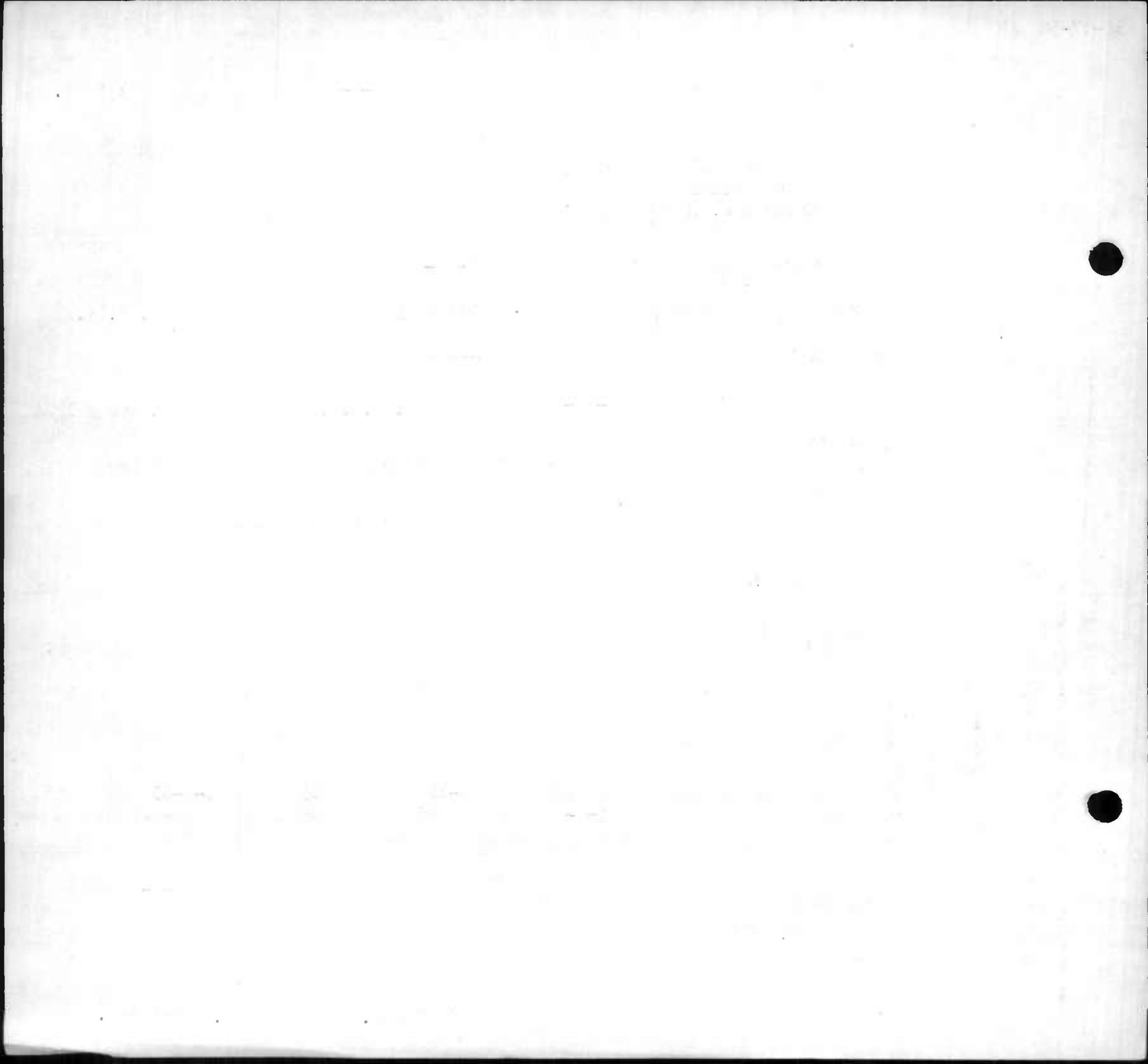
25C. FUNERAL DIRECTOR

William C. March 928 E. North Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





41-54-66

FR

65 4825

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4825

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Herman Allen

2. DATE AND HOUR OF DEATH

May 4, 1965

5:45

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1720 N. Milton Avenue 21213

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-15-1904

9. AGE (In years  
last birthday)

61

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Self employed

10B. KIND OF BUSINESS OR INDUSTRY

Junker

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Herman Allen

14. MOTHER'S MAIDEN NAME

Lottie ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

218-18-9245

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18. 334X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Pneumonia  
DUE TO

2 Weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) slowing the  
UNDERLYING CONDITION last.(B) Cerebral Arterial Disease  
DUE TO

3 Weeks

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April, 12, 19 65 to May 4, 19 65,  
that (I) (we) lost saw the deceased alive on May 4, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Zieve

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 4, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Philip Zieve

23D. ADDRESS

M.D.

4940 Eastern Avenue Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-8-65

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

25B. NAME OF REGISTRAR

Robert E. Fairbank

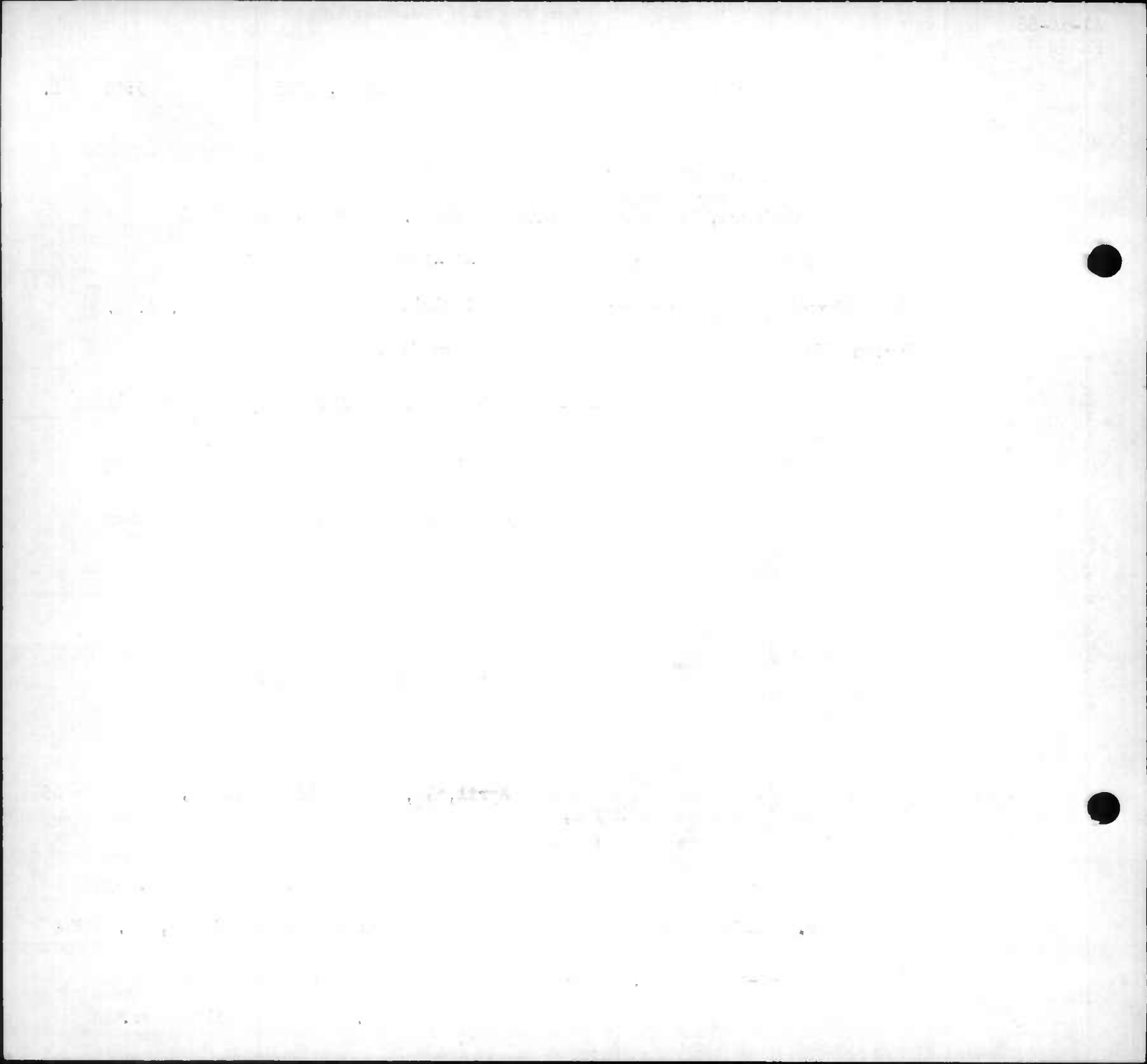
25C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65-10018 65 4826					CERTIFICATE OF DEATH					Registered No. 65 4826				
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Hednum "B"</b>					2. DATE AND HOUR OF DEATH <b>4-30-65 1:45 P.M.</b>									
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21-02</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hosp.</b>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore # 21230.</b>									
D. STREET ADDRESS (If rural, give location) <b>1202 Carroll St.</b>														
5. SEX <b>F.</b>		6. RACE <b>W.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>N.B.</b>		8. DATE OF BIRTH <b>4-29-65</b>		9. AGE (In years last birthday) <b>1</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME <b>Edgar M. Hednum.</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Francis.</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
18. <b>762.5T</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>atelectasis</b>					CAUSE OF DEATH (A) DUE TO <b>Prematurity</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO					<b>1 day</b>				
(C) DUE TO														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <b>2</b>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <b>Yes.</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that <b>she</b> (this hospital) attended the deceased from <b>4-29 1965</b> to <b>4-30 1965</b> , that <b>we</b> last saw the deceased alive on <b>4-30 1965</b> and that in <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>S. Kirchenbauer</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED <b>5-3-65</b>				
23C. PHYSICIAN'S NAME (Type) <b>S. KIRCHENBAUER, M.D.</b>					23D. ADDRESS <b>South Balto. Gen. Hospital 1213 Light St.</b>									
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>MAY 4 1965</b>					24C. NAME OF CEMETERY, CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>					24D. LOCATION (City, town, or county) (State) <b>UNIVERSITY MEDICAL SCHOOL</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>					25C. FUNERAL DIRECTOR ADDRESS <b>MORTUARY SERVICE - BCUH</b>				

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Handwritten text, possibly a date or number, appearing below the central text.

Handwritten text, possibly a signature or name, appearing at the bottom of the page.

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

MORRIS GREEN

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965 8:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

3340 Avondale Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3340 Avondale Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

84

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Hanging  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

3340 Avondale Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 28 65 8:05 a

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Hung self

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-28-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

MAY 4 1965

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

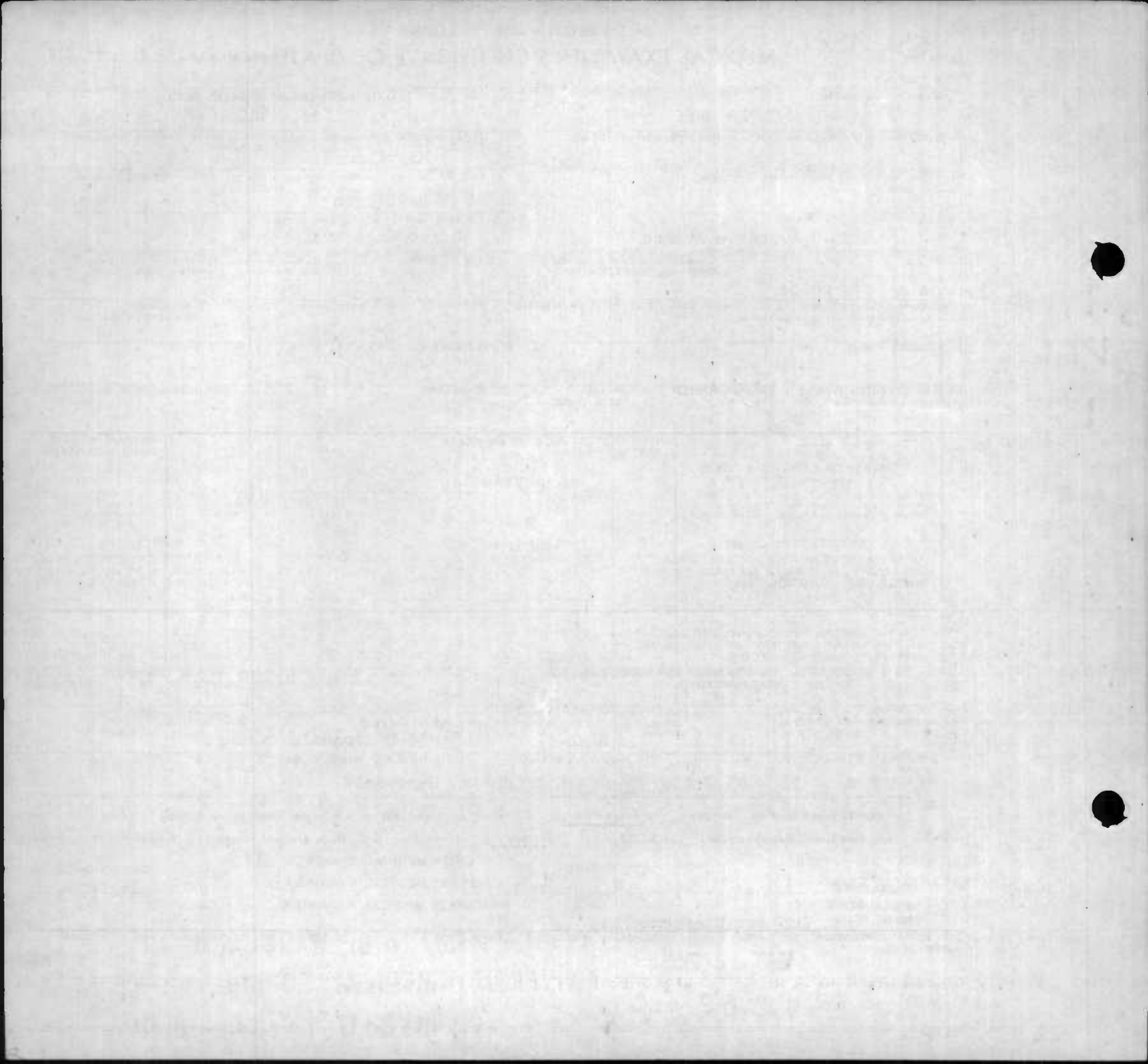
24B. NAME OF REGISTRAR

Robert E. Fairbank

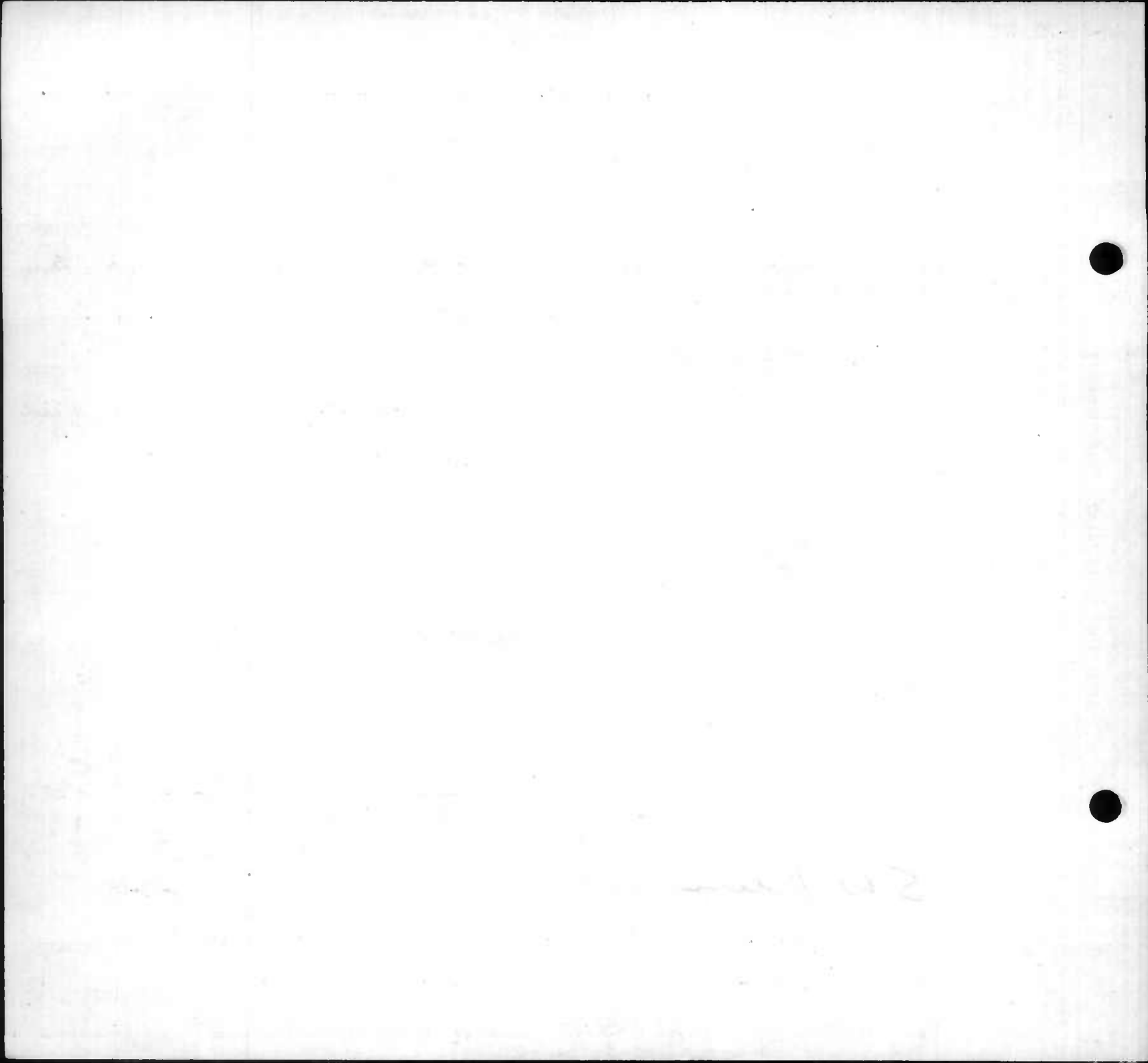
24C. FUNERAL DIRECTOR

ADDRESS

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD









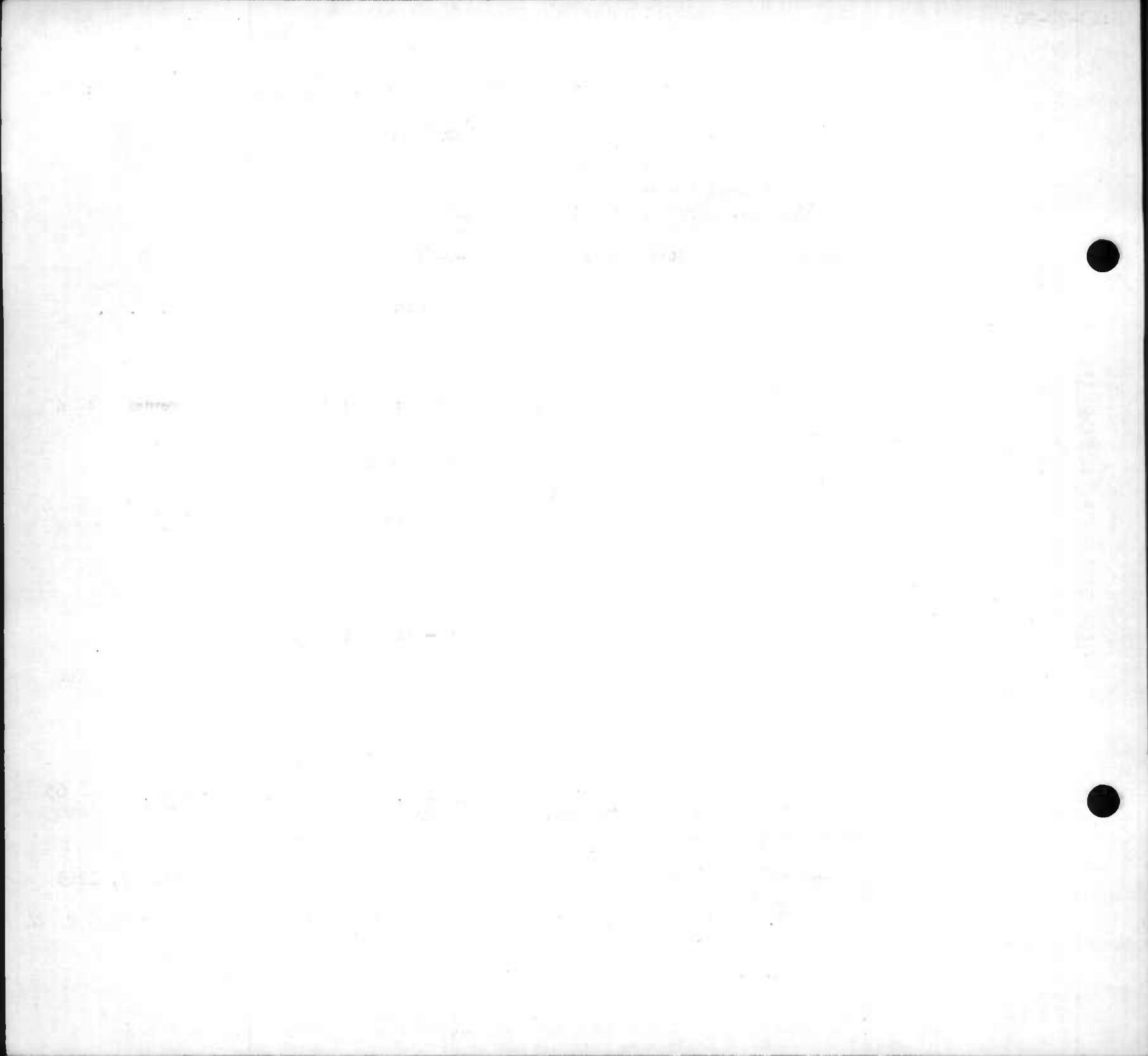
LS:43-30-80

+620

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

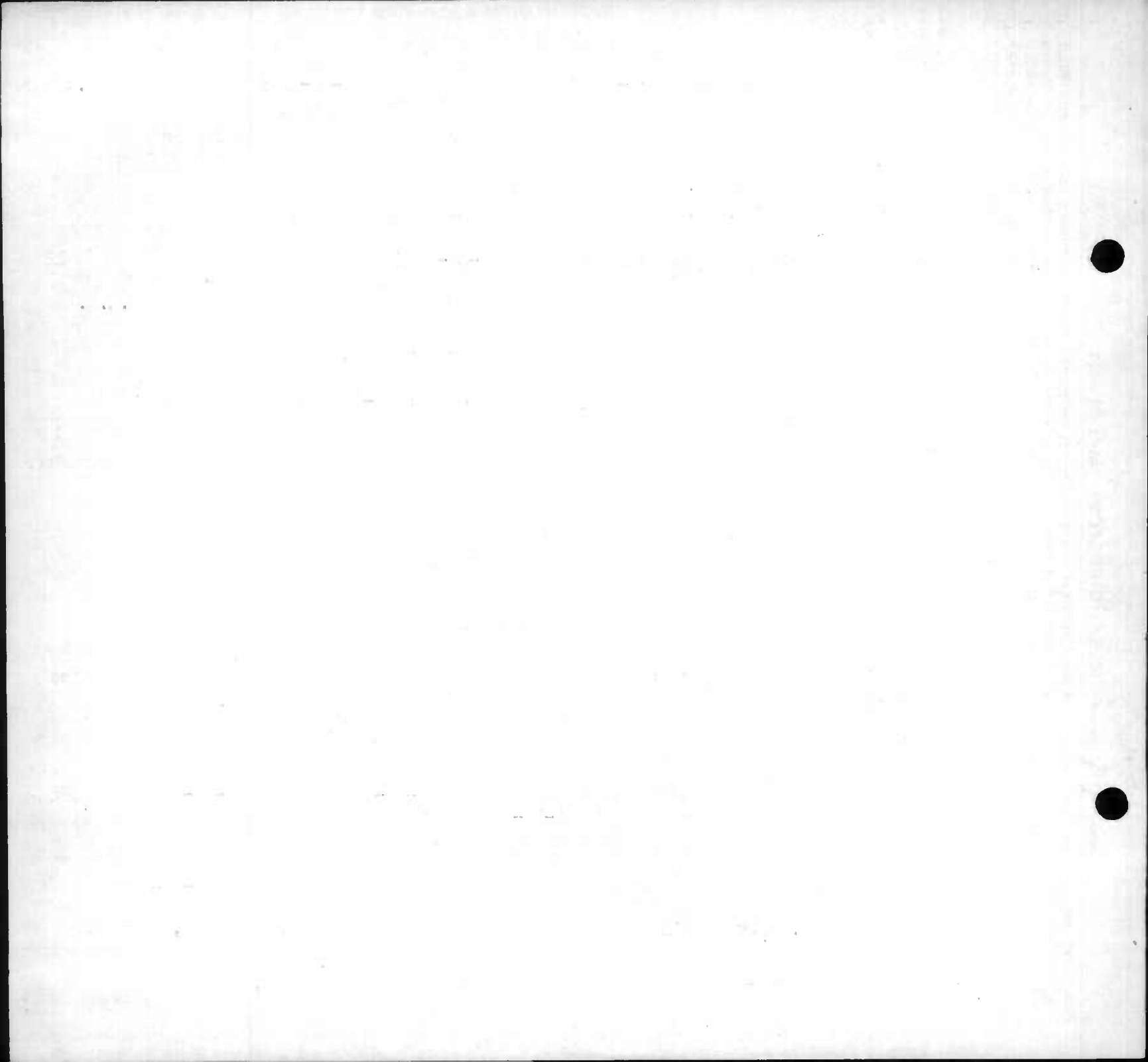
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4829	
BIRTH NO. 6508346 65 4829		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Torres Baby Girl-(B) Ruth		April 27, 1965 4:10 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 610 Appleton Street 21217			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	Negro	Never Married	4-9-65	18	U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
					RECORDS: BCH: 4940 Eastern Avenue #21224
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) Kernicterus			
ANTECEDENT CAUSES		(B) Prematurity, Hyperbilirubinemia			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		Post-Respiratory Distress Syndrome			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 9, 19 65 to April 27, 19 65, that (I) (we) lost saw the deceased alive on April 27, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
S. Wayne Klein				April 27, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Stephen Wayne Klein		M.D. 4940 Eastern Avenue Baltimore Maryland # 24			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremated		4-29-1965		Baltimore City Hospitals	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 6 1965		Robert E. Farkas		HOSPITAL DISPOSAL	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. <b>65-0871065</b> <b>4830</b>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 4830</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Baby Girl Woods-Dorothy</b>		2. DATE AND HOUR OF DEATH <b>4-14-1965</b> <b>1.25A</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Rural</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		D. STREET ADDRESS (If rural, give location) <b>404 Chestnut Court 21222</b>		5300	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Never Married</b>	8. DATE OF BIRTH <b>4-14-1965</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>12</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Dorothy Woods</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>	
18. <b>768.51</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Immaturity</b> DUE TO (B) <b>Premature Labor</b> DUE TO (C) <b>Prom with Amnionitis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 minutes after delivery</b> <b>1 day</b> <b>48 hours</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>? Amnionitis</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-14-1965</b> to <b>4-14-1965</b> , that (I) (we) last saw the deceased alive on <b>4-14-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Wayne Klein</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-14-1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. Wayne Klein</b>		23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE <b>4-20-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore City Hospitals</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>HOSPITAL DISPOSAL</b>	



D-400

BALTIMORE CITY HEALTH DEPARTMENT				65 4831			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Registered No. 65 4831			
1. NAME OF DECEASED (Type or Print) <b>MARGARET DAILEY</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>4/29/65 9:31 p.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>8-04</b> D. STREET ADDRESS (If rural, give location) <b>1219 N. Patterson Pk. Ave.</b>			
5. SEX <b>female</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>9/12/23</b>	9. AGE (In years last birthday) <b>40</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Clover, Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Bratton</b>			14. MOTHER'S MAIDEN NAME <b>Mollie Green</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>216-20-5343</b>		17. INFORMANT <b>Family 1219 N. Patterson Pk Ave.</b>		
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO			
				(C) DUE TO			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, lmn, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>W.U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/30/65</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5/3/65</b>		23C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>		23D. LOCATION (City, town, or county) (State) <b>A.A. County Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 6 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		24C. FUNERAL DIRECTOR <b>Robert E. Williams</b> ADDRESS <b>1701-30 B...</b>			

WALTER H. BROWN  
JANUARY 1941

WALTER H. BROWN

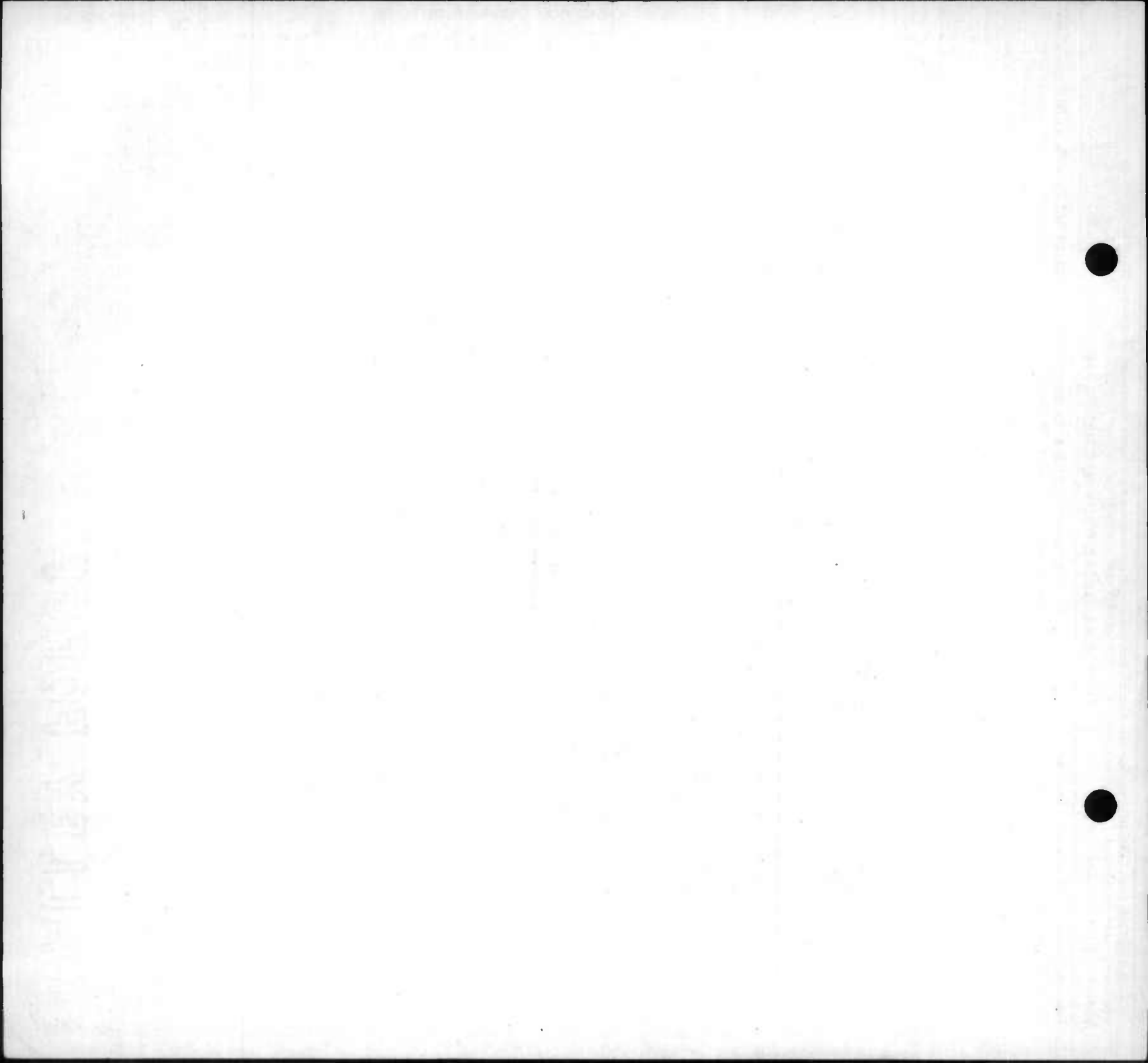
WALTER H. BROWN

WALTER H. BROWN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4832					65 4832				
BIRTH NO.					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
ATHAN TREANDES					MAY 2, 1965 2:10 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE B. COUNTY				
UNION MEMORIAL HOSPITAL					Maryland Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)				
					Baltimore 53-00				
					D. STREET ADDRESS (If rural, give location)				
					1314 Brixton Road				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
MALE	WHITE	MARRIED		1-17-1899	66				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Cook				Restaurant		GREECE		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
James Sotirios					Demetra				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					205-70-278		Mrs. Elizabeth Treandes 1314 Brixton Road, Baltimore, Md. 21212		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					19. CAUSE OF DEATH				
ANTECEDENT CAUSES					Coronary Thrombosis				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					Ischemic Heart Disease				
II					A-V block				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 22 Feb 1965 to 2 May 1965, that (I) (we) last saw the deceased alive on 30 April 1965 and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS			4 May 65	
24A. BURIAL OR CREMATION REMOVAL (Specify)			24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial			5/5/65		Greek Orthodox Cemetery		Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			ADDRESS	
MAY 6 1965			Robert E. Sotirios		Nicholas T. Matthews			3021 Eastern Ave., Baltimore, Md. 21224	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4833

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ANDREW HOPPS

2. DATE AND HOUR PRONOUNCED DEAD

4/29/65 5:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1631 Lamont St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 9-09  
1631 Lamont St. Ave.5. SEX  
male6. RACE  
colored7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Sep

8. DATE OF BIRTH

Apr 25-1915

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Grant Hopps

14. MOTHER'S MAIDEN NAME

Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Catherine Settles 4436 St George Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN IDENTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/30/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

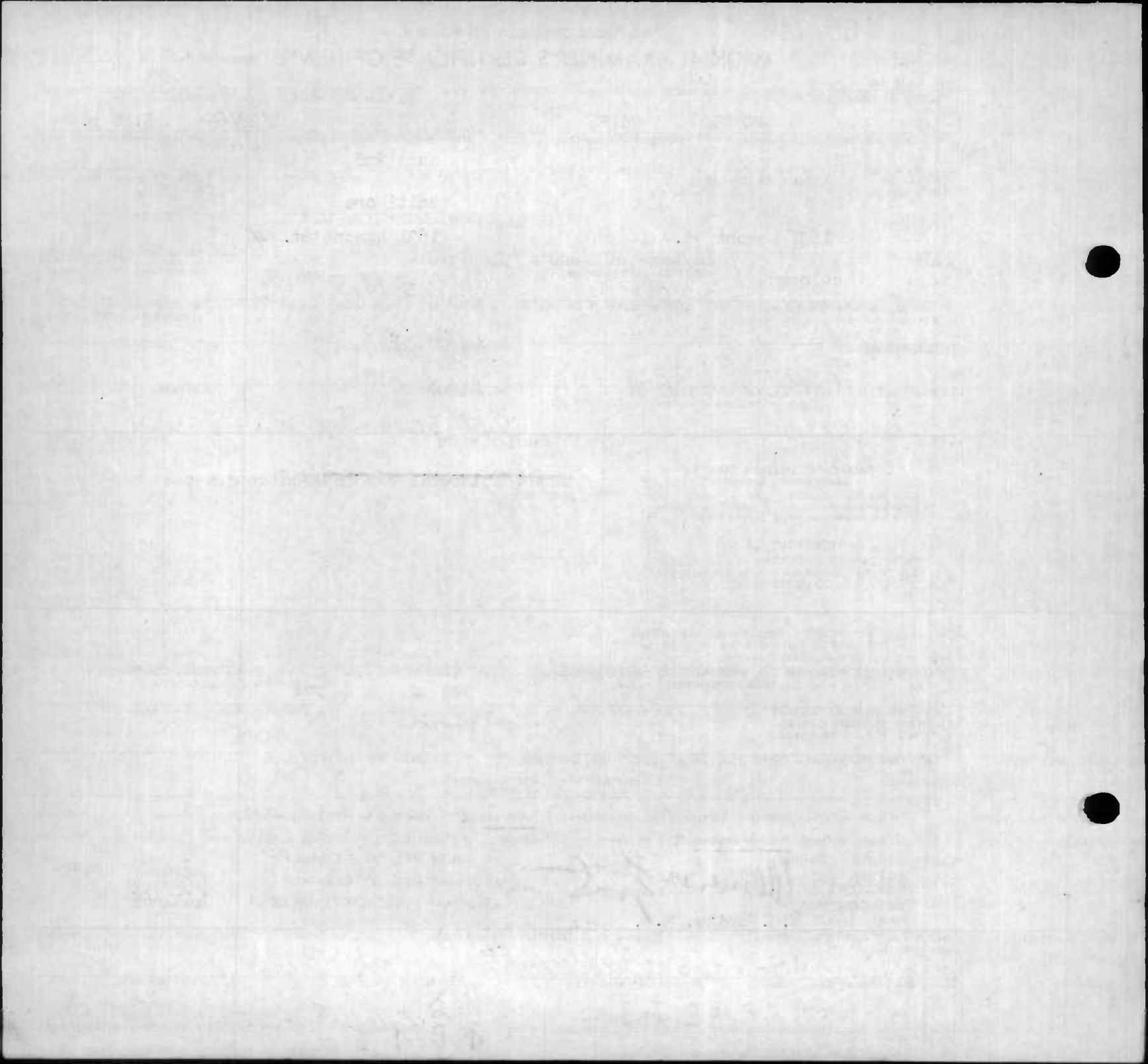
24C. FUNERAL DIRECTOR

ADDRESS

MAY 6 1965

R. E. F. F. F.

R. E. F. F. F. 517 E Preston St



1

65 4834

BALTIMORE CITY HEALTH DEPARTMENT

65 4834

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAURICE HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965 5:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

706 Appleton Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

706 Appleton Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Mar. 22 - 1898 67 65

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retiree

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Hawkins

14. MOTHER'S MAIDEN NAME

Ida Hawkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Sade Harris 24367 Howard St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Gunshot Wound of Chest.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

706 Appleton Street

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 26 '65

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-3-65

23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park Balto

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAY 6 1965

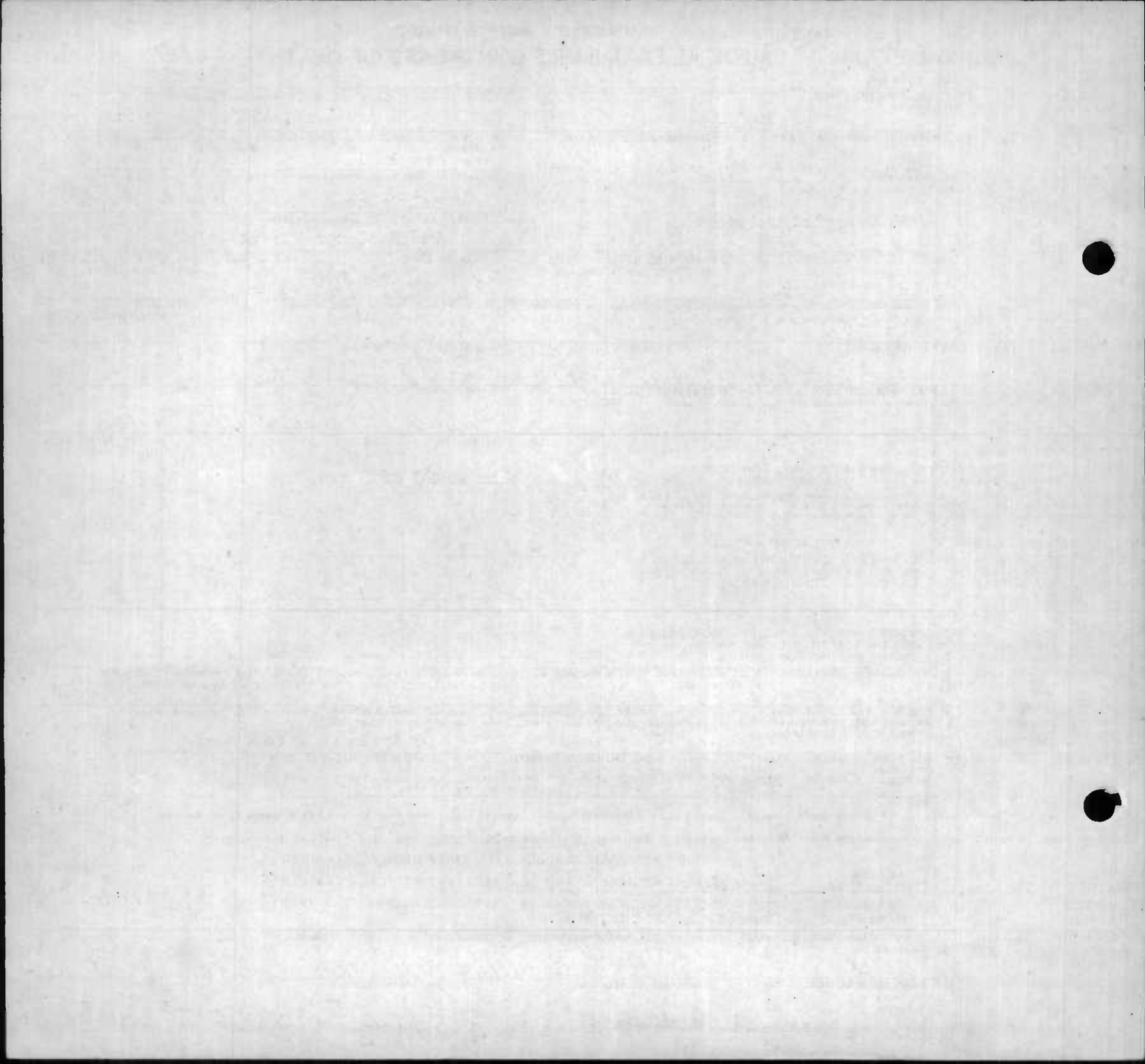
24B. NAME OF REGISTRAR

R. L. B. F. F. F.

24C. FUNERAL DIRECTOR

Rayner Sanders 217 E. Preston St

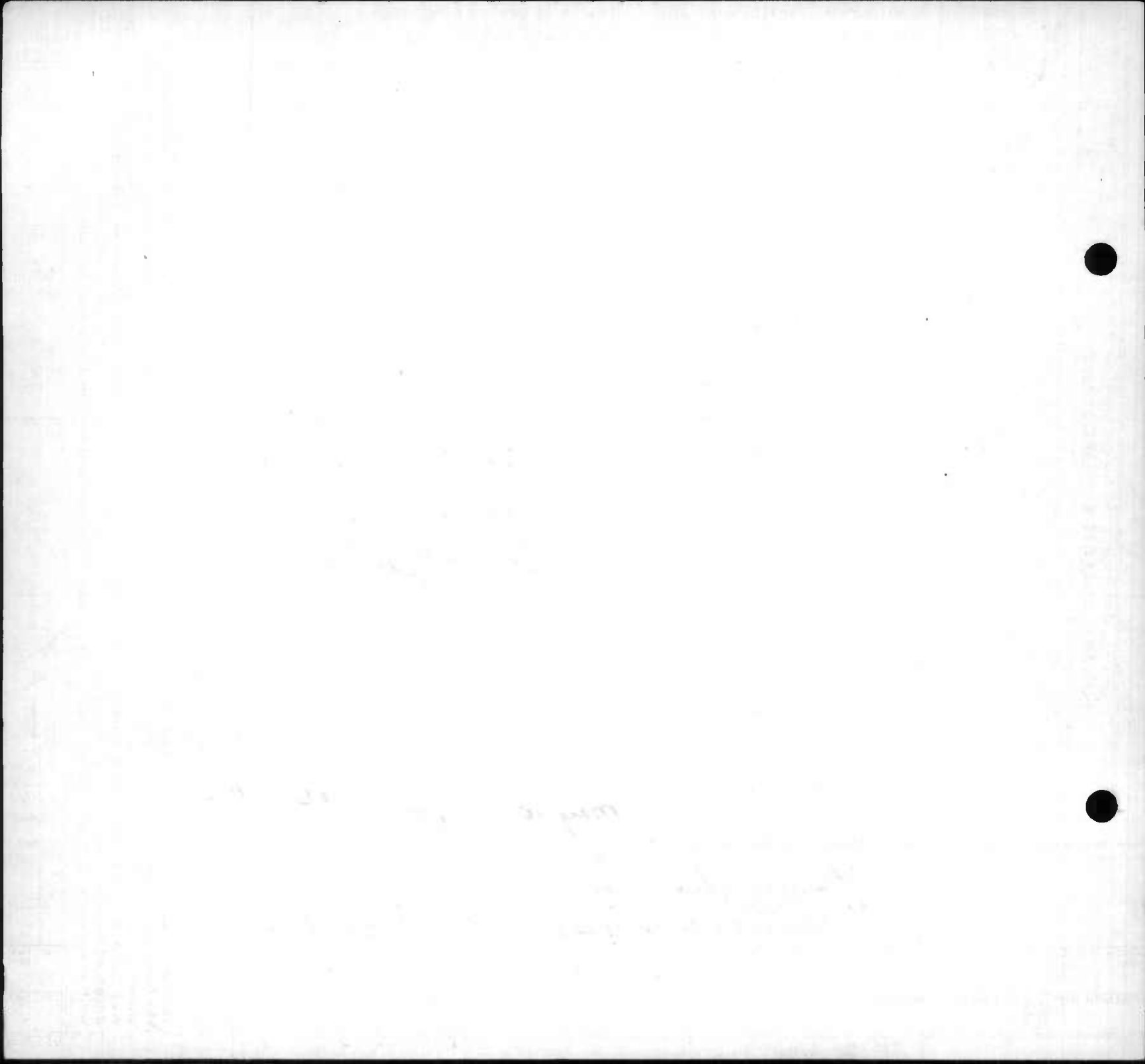
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4835</u>	
<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>65 4835</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <u>MICHAEL GARVEY</u>			2. DATE AND HOUR OF DEATH <u>MAY 4 1965 11:00 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>LITTLE SISTERS OF THE POOR</u> <u>1200 VALLEY STREET</u> <u>BALTIMORE MD 21202</u>			A. STATE <u>MARYLAND</u> B. COUNTY <u>Balt</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>418 HOPKINS ROAD</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>JULY 30, 1877</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months: Days:    If Under 24 Hrs. Hours: Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
13. FATHER'S NAME <u>JAMES F. GARVEY</u>			14. MOTHER'S MAIDEN NAME <u>MARY HANECHAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-28-5707A</u>		17. INFORMANT <u>LITTLE SISTERS OF THE POOR</u>	
18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>acute myocardial infarction</u> (B) <u>generalized arteriosclerosis</u> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>May 4</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 10</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Stanley Ankudav</u>				23B. DATE SIGNED <u>5.6.65</u>	
23C. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u>				23D. ADDRESS <u>1802 W. Baet &amp; Baet St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 7</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wash-Bedau Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Philip Herurg Sons Orleans St</u>			
25D. ADDRESS <u>2024</u>					

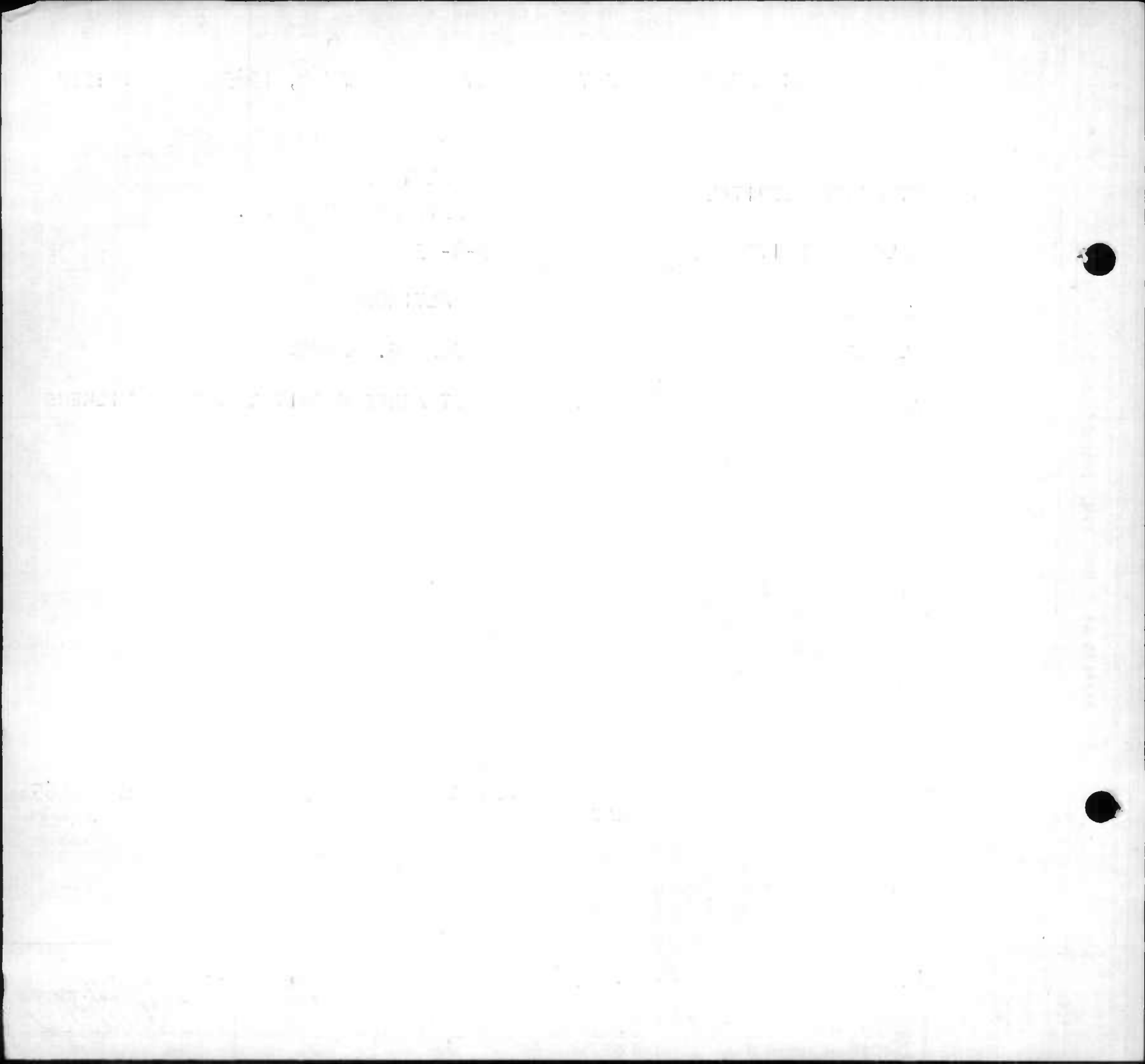




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.


BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65-10845 65 4836					CERTIFICATE OF DEATH X Registered No. 65 4836				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) MC MAHON			BABY		BOY		2. DATE AND HOUR OF DEATH MAY 4, 1965		12:32P M.
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE MD B. COUNTY Baltimore				
40 ST AGNES HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 5517 ASHBOURNE RD.				
5. SEX MALE		6. RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married		8. DATE OF BIRTH 5-4-65		9. AGE (In years last birthday) 1 6	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None					10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME LEONARD					14. MOTHER'S MAIDEN NAME JOAN G. HARVEY				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS		
18. CAUSE OF DEATH									
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)					(A) Prematurity				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
MEDICAL CERTIFICATION									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 4 1965 to MAY 4 5- 19 65, that (I) (we) last saw the deceased alive on MAY 4 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edwin V. J. Grawen					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5/5/65	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			25B. NAME OF REGISTRAR Robert E. Edwards			25C. FUNERAL DIRECTOR 1328 Sulphur Springs Rd. James J. Miller			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 4837	
CERTIFICATE OF DEATH				Registered No. 65 4837	
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		WILLIAM F. STROMBERG		2. DATE AND HOUR OF DEATH MAY 5, 1965 10:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE 29, MD.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ZONE 29 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4204 WILKENS AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-17-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN Stromberg			14. MOTHER'S MAIDEN NAME ANNA STEVER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-14-1134		17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ASCVD			INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 5 19 65 to MAY 5 19 65, that (I) (we) last saw the deceased alive on MAY 5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D.				23B. DATE SIGNED 5-5-65	
23C. PHYSICIAN'S NAME (Type) MIGUEL HEREDIA			23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Wilkins Avenue, Balto., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR Howard H. Hubbard - 4107 Wilkins Ave Balto Md	

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# FUNERAL DIRECTOR: IMPORTANT

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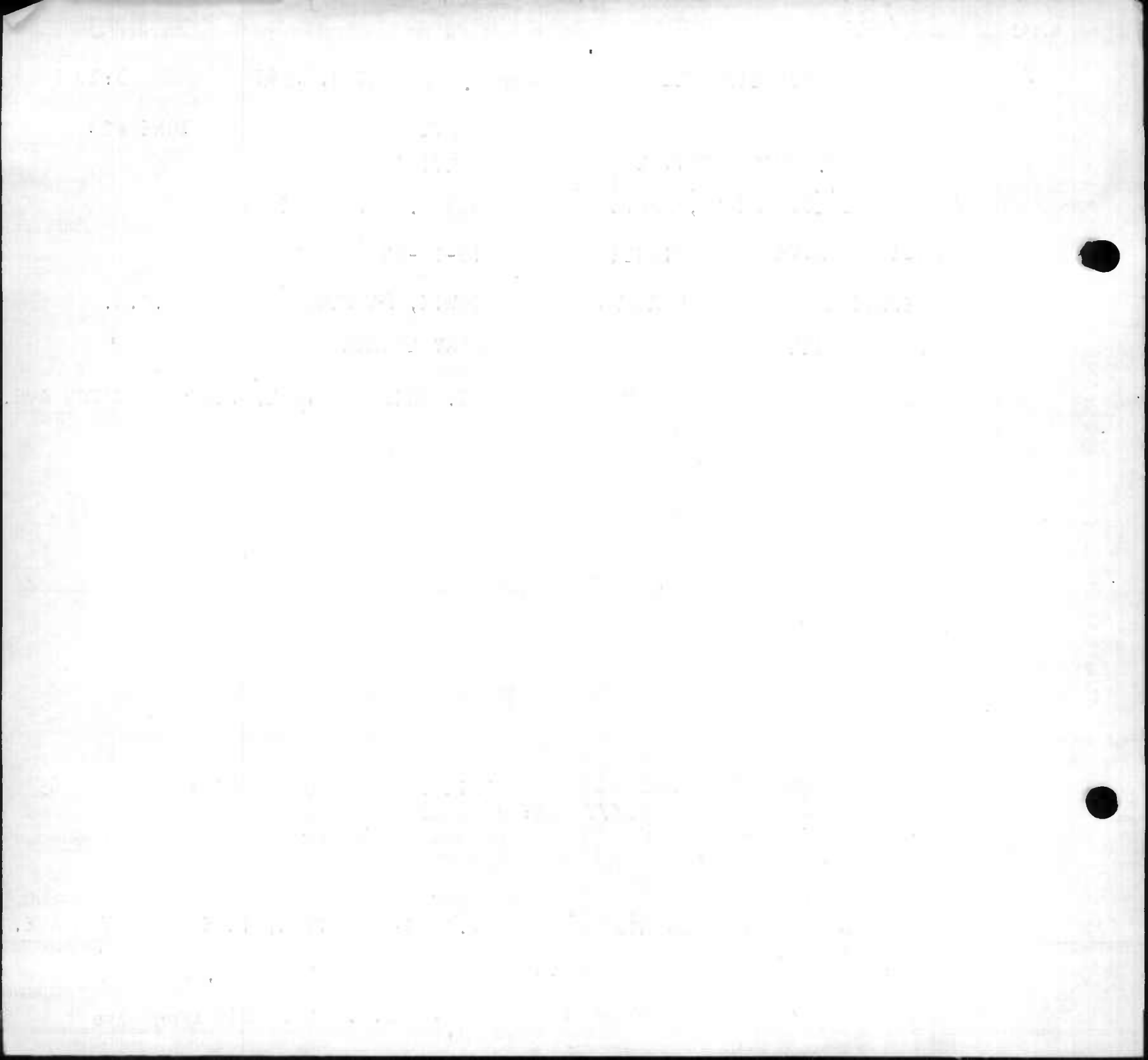
Baltimore City Health Department				Registered No.	
BIRTH NO.		65 4838		65 4838	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
MR. HARRY WASHINGTON LEWIS			5-5-65 3:15 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
4 UNION MEMORIAL HOSPITAL			MARYLAND Baltimore		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			BALTIMORE 21212 27-38		
			D. STREET ADDRESS (If rural, give location)		
			5687 PERDUE DRIVE PERDUE AVE		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	<del>W</del>	4-29-89	76	C.A.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				NEW YORK	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
JOSEPH LEWIS			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			090-09-7658		WIFE ADDRESS SAME
			MRS. ETHEL M. LEWIS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Uremia		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from May 5 1965 to May 5 1965. that (I) (we) last saw the deceased alive on May 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles T. Fletcher				May 5, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CHARLES T. FLETCHER				Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-8-65		London Park Cemetery	
				Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 7 1965		Robert E. Fisher		Eugenia H. Seitz 5209 York R	
Seitz Funeral Home Baltimore, Md.					

WILLIAM BOWEN

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

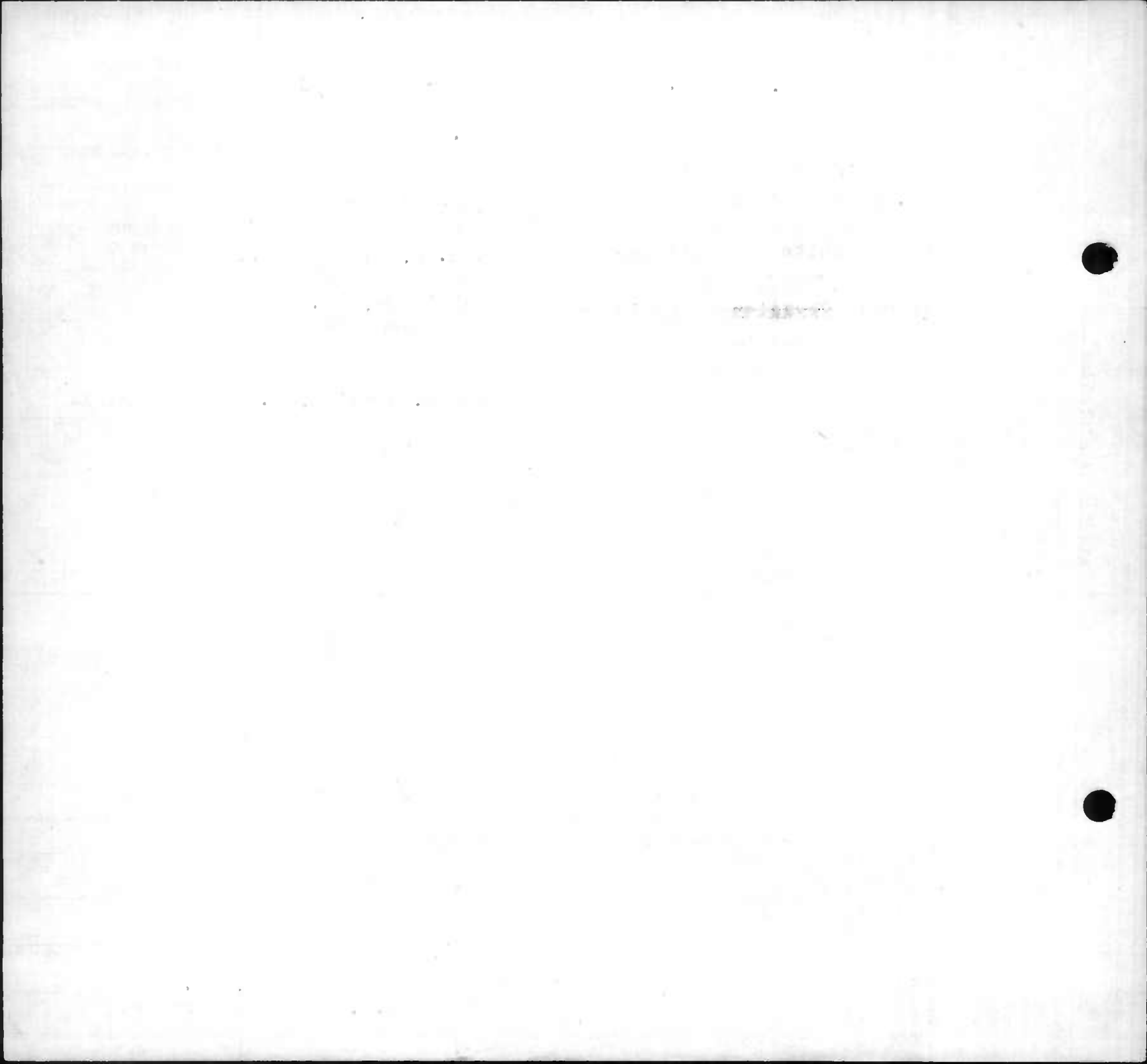
BIRTH NO. <b>65 4839</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 4839</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>STANLEY BELL (Stanislaus A. Bell)</b>		<b>MAY 4, 1965</b>		<b>3:20 P M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE 29, MARYLAND</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>ZONE #29</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>405 S. CATON AVENUE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>10-16-02</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>BOWIE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>THOMAS BELL</b>		14. MOTHER'S MAIDEN NAME <b>MARY LANHAM</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216090123</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Esophagus</b>		CAUSE OF DEATH (A) DUE TO <b>Carcinoma Esophagus</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Malignant cachexia</b>		(B) DUE TO <b>Malignant cachexia</b>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>APRIL 10</b> 19 <b>65</b> to <b>MAY 4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>MAY 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ramchandra Ramnath</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/4/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAMCHANDRA RAMNATH</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [illegible]</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>3</b>		<b>65 4840</b>		<b>65 4840</b>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<b>Dr. John A. Tompkins</b>		<b>May 4/65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>House in Pines Nursing Home</b> <b>W. Belvedere Ave</b>		A. STATE <b>Md.</b>			
		B. COUNTY <b>27-09</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 12</b>			
		D. STREET ADDRESS (If rural, give location) <b>1631 Winford Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 5, 1871</b>	9. AGE (In years lost birthday) <b>93</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Physician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Tompkins</b>			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>John A. Tompkins, Jr.</b>			
18. <b>491 X I</b>		ADDRESS <b>1631 Winford Rd</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Cardiac Failure</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Bronchial Pneumonia</b> DUE TO			<b>11 days.</b>
(C)					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 23 1965</b> to <b>May 4, 1965</b> 19 <b>1965</b> that (I) (we) last saw the deceased alive on <b>May 4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>George E. Shannon</b>				23B. DATE SIGNED <b>May 5, 1965</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Burial</b>		<b>May 7/65</b>		<b>Arlington National</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>MAY 7 1965</b>		<b>Robert E. Finkbeiner</b>		<b>Witzke F.D. 4101 Edmondson Ave</b>	
25D. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>					





## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65

4841

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

4841

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ARTHUR

HURLEY

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1965

11:42 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3218 Lyndale Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

5-21-1928

9. AGE (In years  
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

T.V. Repairman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edgar R. Hurley

14. MOTHER'S MAIDEN NAME

Grace Neubauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

214-22-2709

17. INFORMANT

ADDRESS

Edgar R. 605. MACON ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5/6/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/10/65

23C. NAME of CEMETERY or CREMATORY

Oaklawn

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 7 1965

24B. NAME OF REGISTRAR

Robert E. Fink

24C. FUNERAL DIRECTOR

ADDRESS

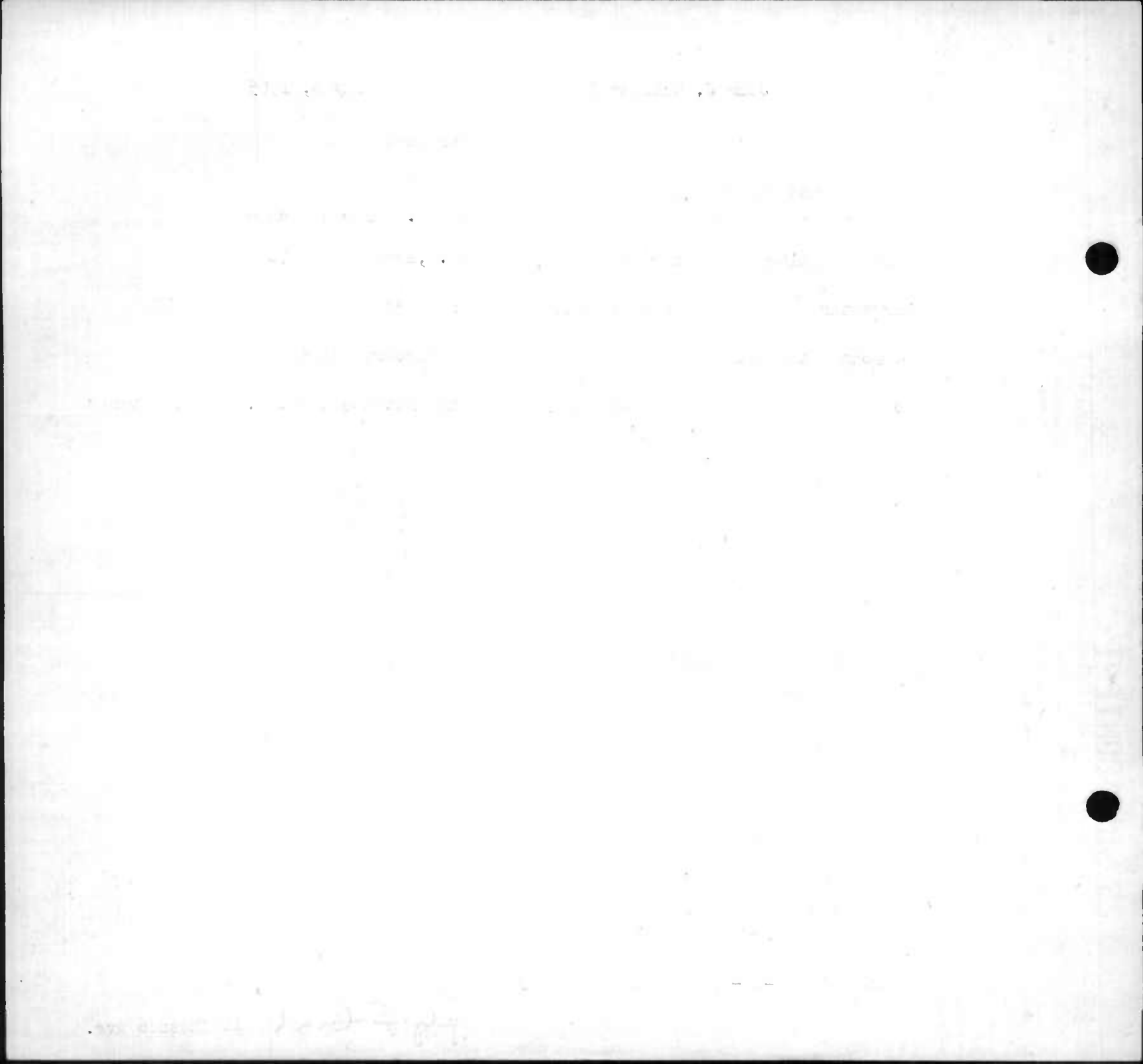
Joseph N. Ziemann 263 S. Conkling St.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

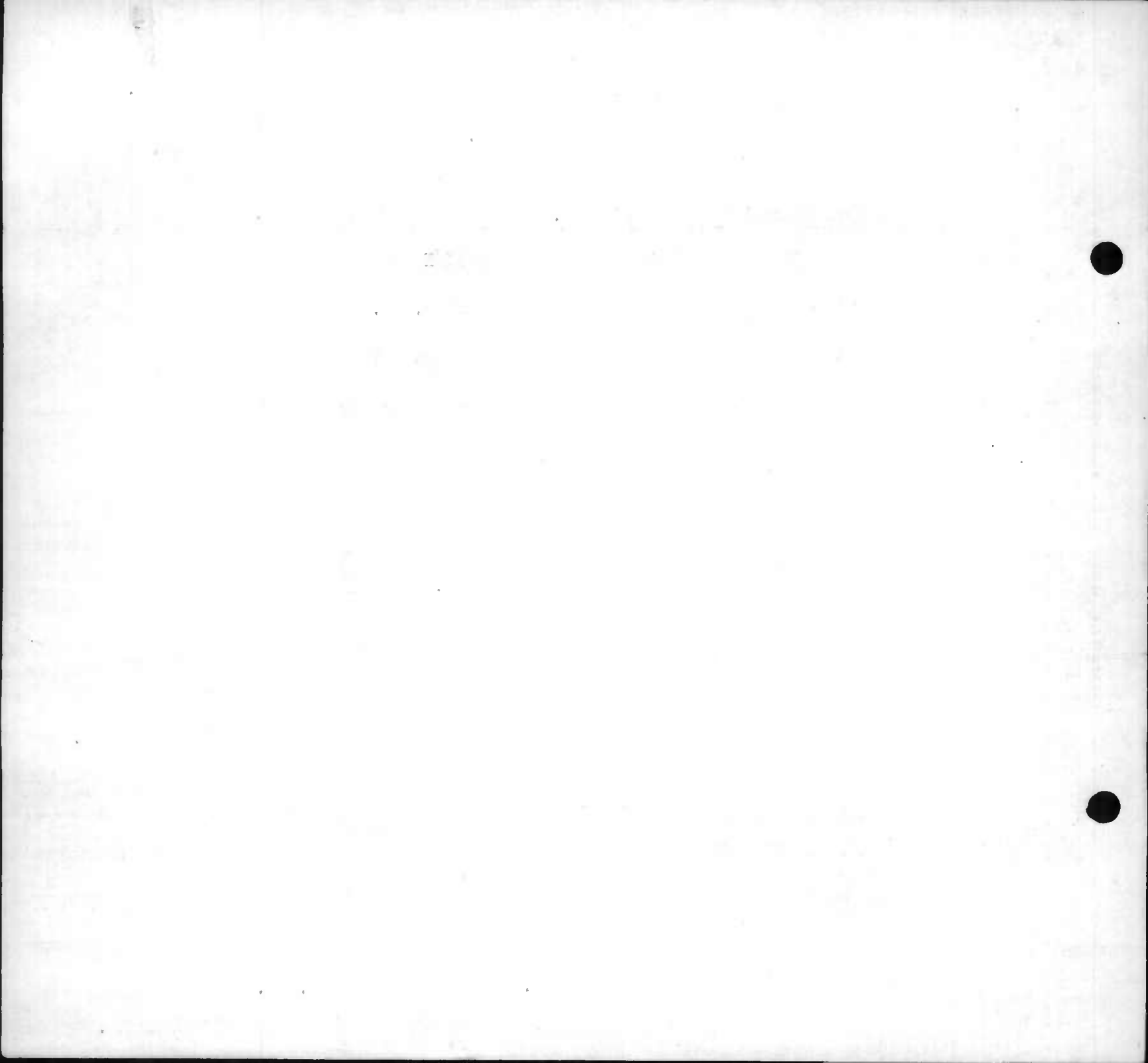
BIRTH NO. 65 4842				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4842							
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
				John J. Rutkowski				May 5, 1965 2:30 P.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY							
Johns Hopkins Hospital				Maryland				Baltimore							
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)											
				D. STREET ADDRESS (If rural, give location)				622 N. Belnord Avenue							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
Male	White	Married	Aug. 6, 1888	76	Carpenter	Maryland	USA	John Rutkowski	Barbara Kalla	No	216 10 3278	Anna Rutkowski	622 N. Belnord Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH							
ANTECEDENT CAUSES				(A) DUE TO				5 minutes							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO				?							
II				(C) DUE TO											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)							
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?							
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>											
22. I certify that (I) <del>this hospital</del> attended the deceased from Jan 10 1965 to May 5 1965 that (I) (we) last saw the deceased alive on May 5 1965 and that in my <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> (did not) view the body after death.															
23A. SIGNATURE								M.D.		Attending Phys. <input checked="" type="checkbox"/>		Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23B. DATE SIGNED												5/5/65			
23C. PHYSICIAN'S NAME (Type)								M.D.		23D. ADDRESS					
JOSEPH POKORNY										2200 E Madison St Balto 5, Md					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Burial				5-10-65				Holy Redeemer Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR				ADDRESS			
MAY 7 1965				Robert E. Tarkenton				Philip J. Goch				1211 Chesaco Ave.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

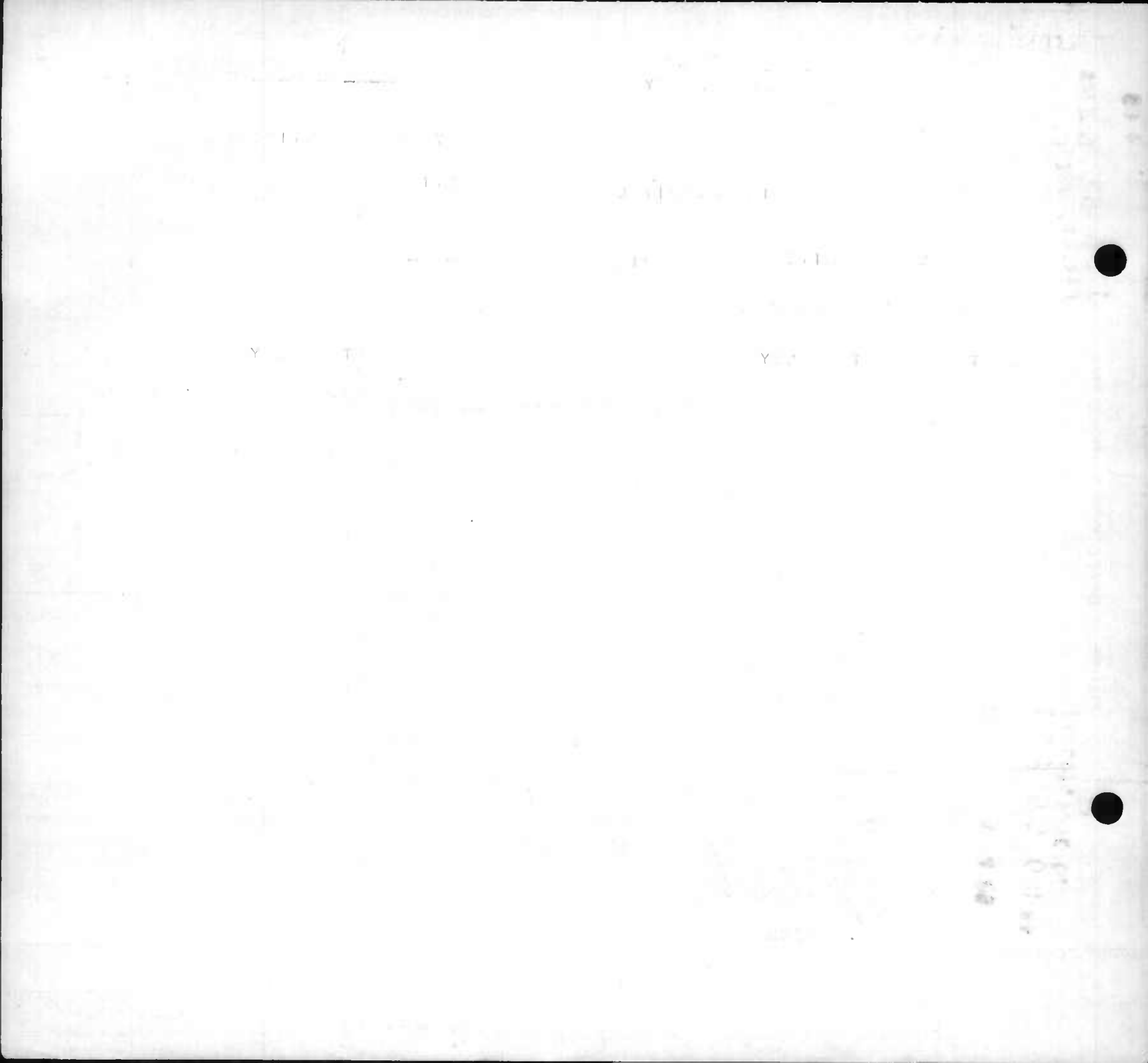
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4843	
BIRTH NO. 65 4843				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Lena E Brauer</b>			May 4 1965 11.45 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Gould Convelesarium 6116 Belair Rd.			Md. 26-01		
5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
8. DATE OF BIRTH 8/31/1868 9. AGE (In years lost birthday) 96			D. STREET ADDRESS (If rural, give location)		
			4213 Springwood Ave.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country)		
			Balto. Md.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ? Weber			14. MOTHER'S MAIDEN NAME Anna E ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None		
			17. INFORMANT ADDRESS		
			David W Brauer 4509 The Alameda		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
			Yes.		
			Yes.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 1965 to 5/4/65 1965, that (I) (we) lost saw the deceased alive on 5/3/65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Walter E. Fickel M.D.			5/5/65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			4331 Hays Rd. M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		
Burial			4/8/65		
24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)		
Parkwood Cem.			Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR		
MAY 7 1965			Lassahn Funeral Home 7401 Belair Rd.		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) A fracture of any kind; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4844		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4844	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPHAS JOE FARLEY</b>		2. DATE AND HOUR OF DEATH <b>5-4-65 5-4-65 3:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>624 CARVEL ROAD</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-17-89</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coast Guard (Retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>ROBERT FARLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET FARLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-12-1283</b>		17. INFORMANT <b>Wife (Same as above)</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HASCUID</b>			CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>11 PM 5/4 1965</b> to <b>2 PM 5/4 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>5/4 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do</del> ) view the body after death.					
23A. SIGNATURE <b>M. Lesch</b>				23B. DATE SIGNED <b>5/4</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. LESCH</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fader</b>		25C. FUNERAL DIRECTOR <b>Copnelly</b>	
25D. ADDRESS <b>300 Mace Ave. Balto. 21</b>					



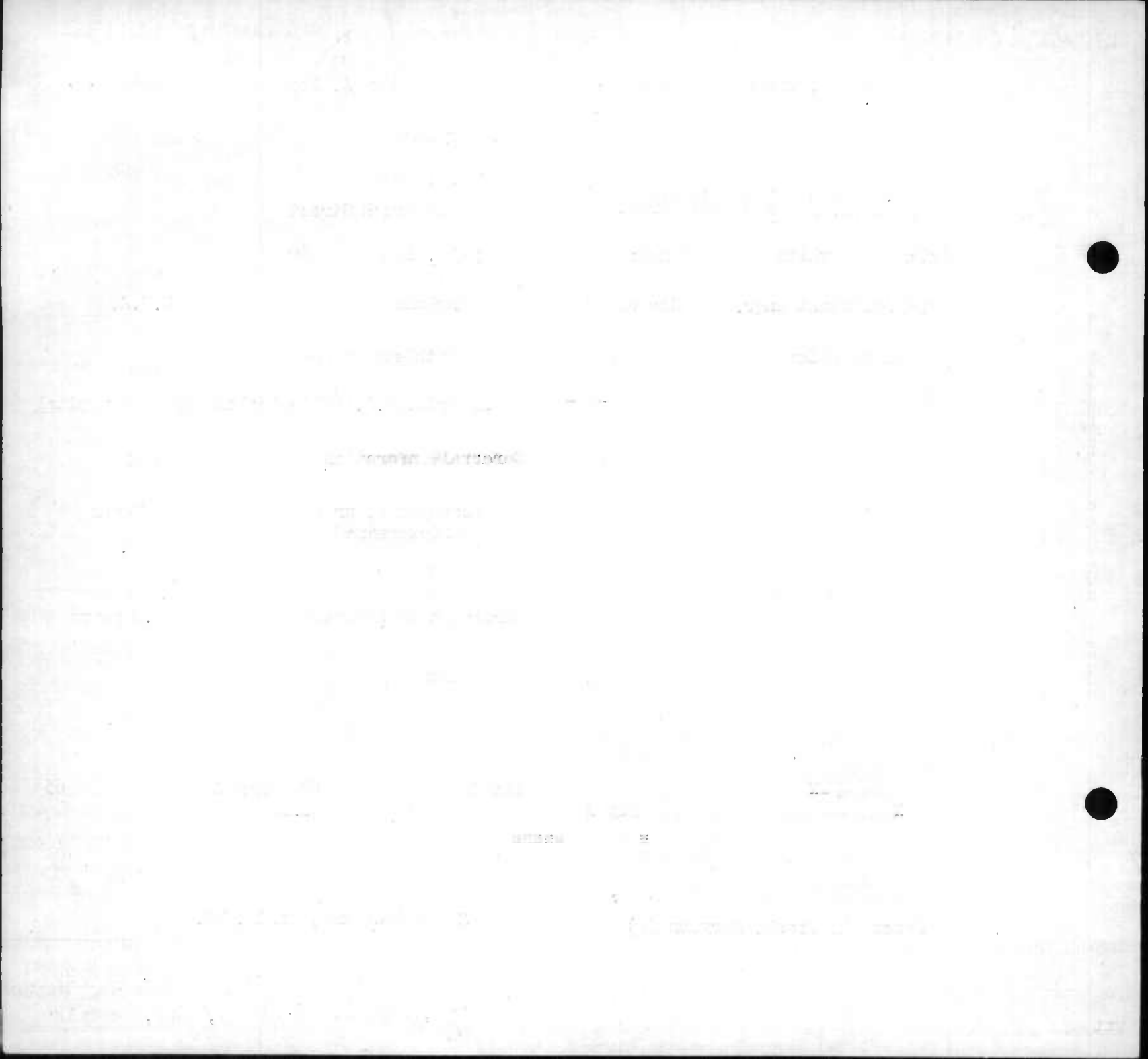


R-360

## FUNERAL DIRECTOR: IMPORTANT

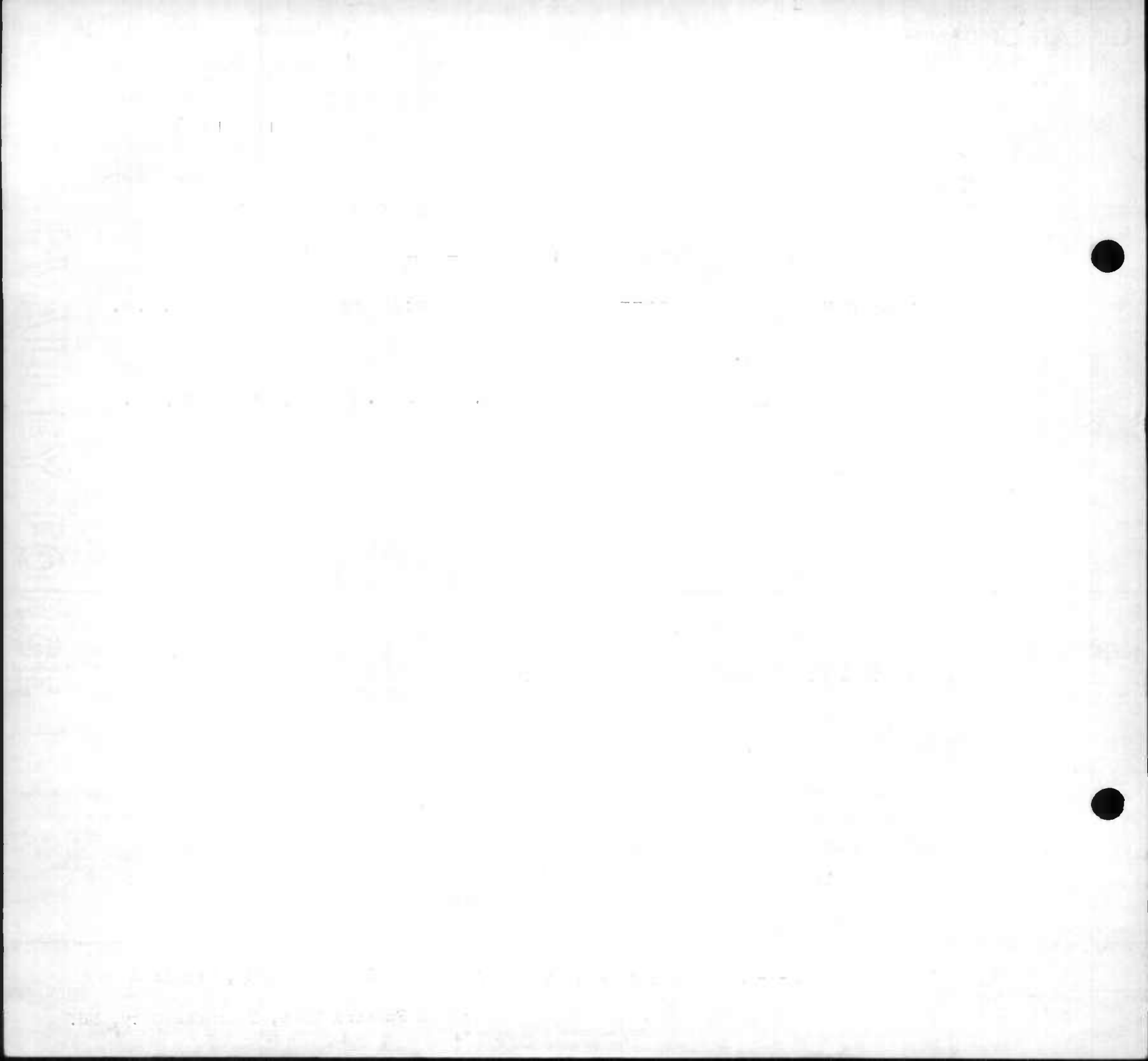
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4845				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4845	
1. NAME OF DECEASED (Type or Print) Rider, Thomas Frederick				2. DATE AND HOUR OF DEATH May 4, 1965		1:05 P.M. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.S. Public Health Service Hospital Wyman Pk. Drive & 31st Street				D. STREET ADDRESS (If rural, give location) 8023 Gough Street					
5. SEX Male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH May 30, 1895	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 3rd Assistant Engr.		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Rider			14. MOTHER'S MAIDEN NAME Kathleen Hammond			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 460-10-9846			17. INFORMANT Records, U.S. Public Health Service Hospital				ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral infarction				CAUSE OF DEATH (A) DUE TO Cerebral infarction		INTERVAL BETWEEN ONSET AND DEATH Days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma, primary site				(B) DUE TO undetermined		Years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of prostate						10 years			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from May 1 19 65 to May 4 19 65, that (we) last saw the deceased alive on May 4 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.									
23A. SIGNATURE James H. Frank				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/4/65			
23C. PHYSICIAN'S NAME (Type) James H. Frank, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 5/5/65		24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21202			
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965		25B. NAME OF REGISTRAR Robert E. Farley		25C. FUNERAL DIRECTOR Walter Brooks Bradley, Inc.		ADDRESS Dundalk			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

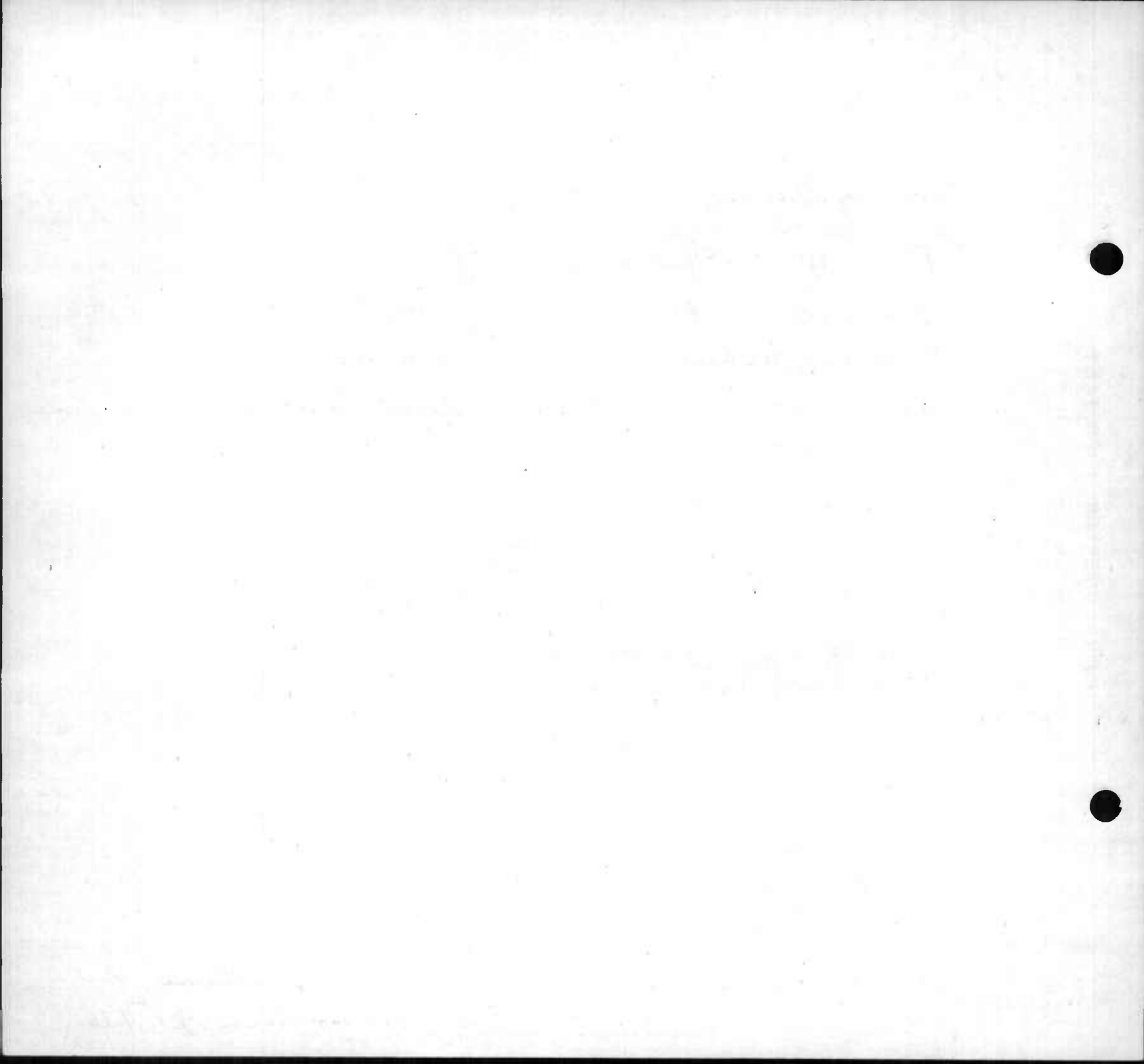
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4846</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 4846</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">MICHAEL OUTTEN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 3, 1965</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">(WICOMICO)</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">SALISBURY</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">Beagline Park Drive</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">NEVER MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">4-16-49</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">16</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Schoolboy</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">----</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Delaware</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">EDWARD L. OUTTEN</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">JEAN MILLIGAN</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mr. Edward L. Outten, Salisbury, Md.</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">CARDIAC ARREST</span>				INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 day</span>			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.2em;">COMPLETE HEPATO-RENAL SYNDROME</span> <span style="font-size: 1.2em;">BANT'S SYNDROME - POST-NECROTIC CIRRHOSIS</span>				<span style="font-size: 1.2em;">2 YEARS</span>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">4-24-65</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">UPPER GASTRO-INTESTINAL HEMORRHAGE</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.2em;">APRIL 20, 1965</span> to <span style="font-size: 1.2em;">MAY 3, 1965</span> , that (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 3, 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">A. Douglas Logue</span> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5-3-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DRA DOUGLAS LOGUE</span> M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-6-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">First Baptist Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Pocomoke City, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 7 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">Watson Funeral Home, Pocomoke City, Md.</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

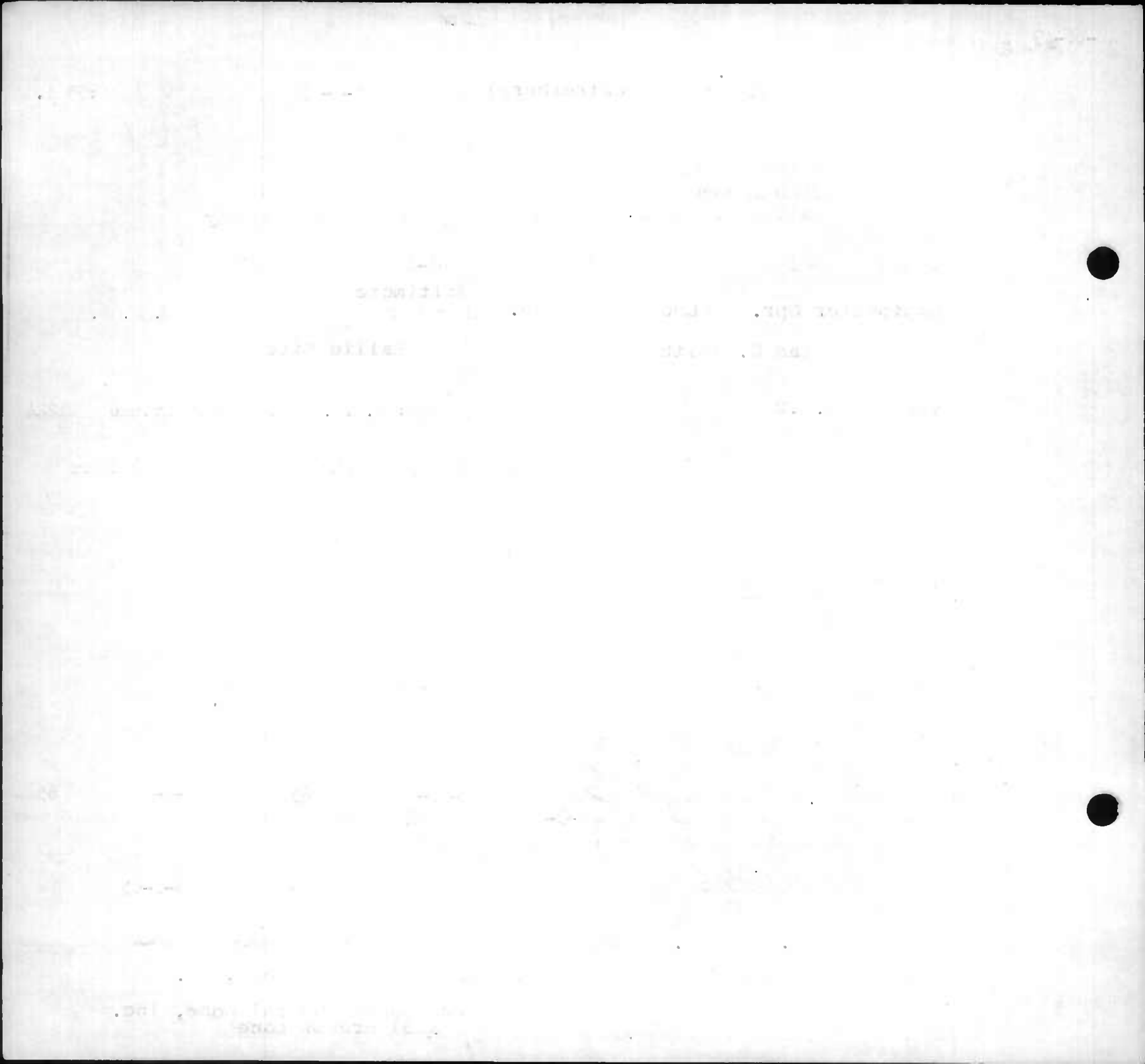
BIRTH NO. 65 4847				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4847	
1. NAME OF DECEASED (Type or Print) JULIA MAUDE FORD				2. DATE AND HOUR OF DEATH 5/4/65 11 P. M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 18-03					
FULL NAME OF HOSPITAL OR INSTITUTION 90 Century Nursing Home				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) 40 S. Poppleton St.					
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/28/1882	9. AGE (In years last birthday) 83	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Jarboe				14. MOTHER'S MAIDEN NAME Mary Donnelly				ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mr Robert Ford		ADDRESS 532 Wyandale Ave - 18			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X1 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO Cardio-Respiratory Failure massive Central Vascular Accident (B) DUE TO Arteriosclerotic-Hypertensive CVD Gen. arteriosclerosis (C) DUE TO Senility				INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept. 3, 1964 to May 4, 1965, that (I) (we) last saw the deceased alive on May 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Willard Appleby				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/6/65			
23C. PHYSICIAN'S NAME (Type) Willard Appleby				23D. ADDRESS M.D. 5901 Park Heights Dr.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/65		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR John J. Brown + Son Inc.		ADDRESS 901 Hallens St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT						Registered No. <b>65 4848</b>	
BIRTH NO. <b>65 4848</b>		<b>CERTIFICATE OF DEATH</b>					
M.E. CASE NO.		1. NAME OF DECEASED <b>R. Mary Dixon (Leatherbury)</b>				2. DATE AND HOUR OF DEATH <b>5-3-65 10:55 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				D. STREET ADDRESS (If rural, give location) <b>2403 East Northern Parkway</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>3-4-18</b>	9. AGE (In years last birthday) <b>47</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptometer Opr.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lock Keys Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William E. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Kite</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes W.W.2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Hypernephroma</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 Years</b>	
19. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-21-1965</b> to <b>5-3-1965</b> , that (I) (we) last saw the deceased alive on <b>5-3-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Howard K. Rathbun</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Howard K. Rathbun</b>				23D. ADDRESS <b>4940 Eastern Avenue #21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. F...</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>			

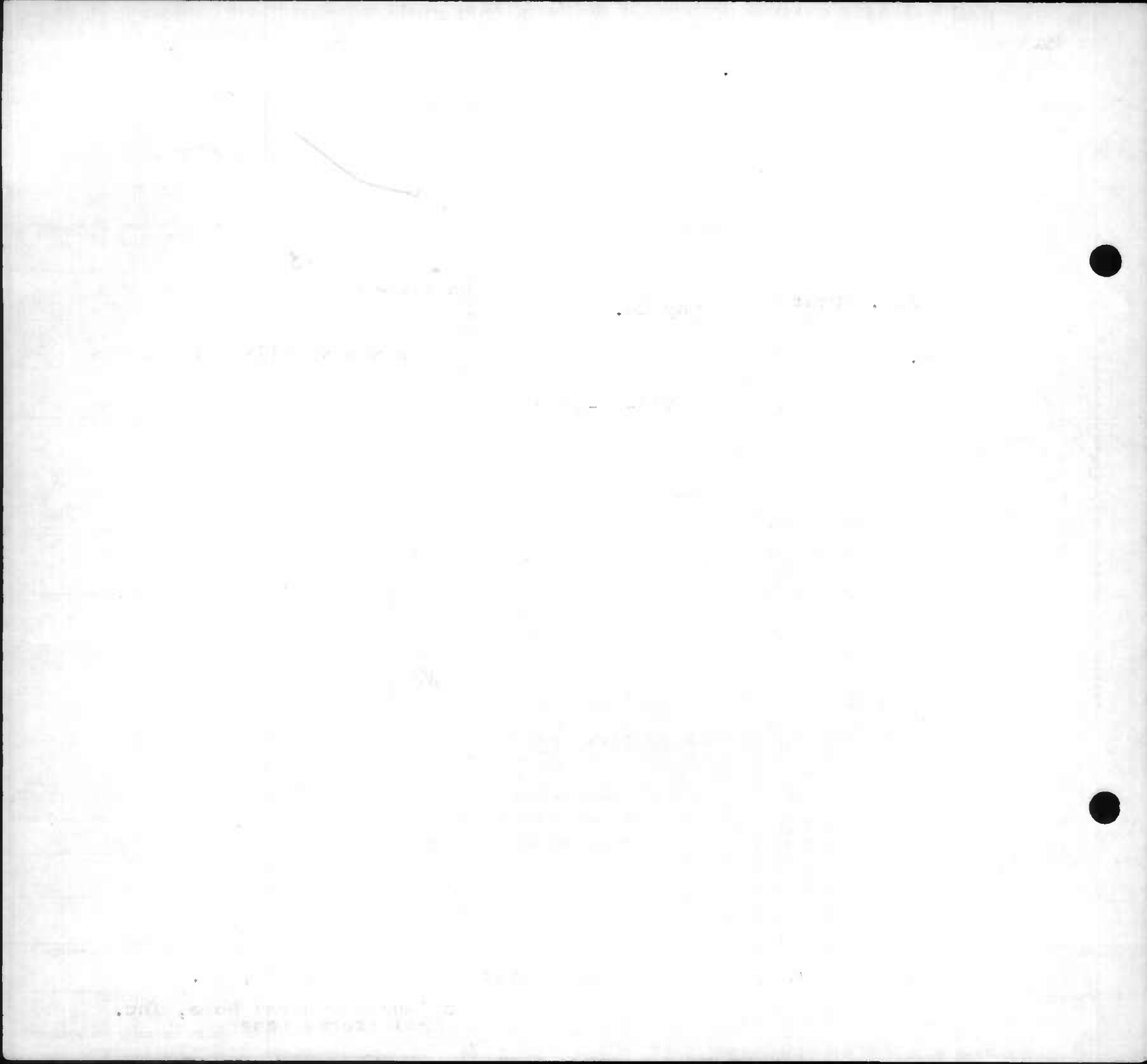




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4849					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4849				
1. NAME OF DECEASED (Type or Print) <b>LILLIAN M. KING</b>					2. DATE AND HOUR OF DEATH <b>5/4/65 11:35 P. M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL 827 LINDEN AVE. BALTO 12, MD.</b>					A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTE</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 22 5300</b>				
					D. STREET ADDRESS (If rural, give location) <b>3921 NORTHPOINT Rd.</b>				
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>8/29/1899</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Buyer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>May Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Wm. FARDLEY</b>					14. MOTHER'S MAIDEN NAME <b>XXXXXXXXX Elizabeth Hughes</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>215-03-1509</b>		17. INFORMANT ADDRESS <b>MARYLAND GENER HOSP. 827 LINDEN AVE.</b>				
18. <b>420.0 I</b>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					(A) <b>CEREBRAL THROMBOSIS</b> DUE TO				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) <b>ASHD</b> DUE TO				
					(C) <b>Pneumonitis</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> 19 <b>65</b> to <b>5/4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Pietro Lastman</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/4/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>LASTRUCCI PIETRO</b>					23D. ADDRESS M.D. <b>MARYLAND GEN. HOSP.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Schumnek</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Schumnek Funeral Home, Inc. 3331 Brehms Lane</b>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO.		65 4850				65 4850	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
STARKLOFF, ESTELLE MARIE				May 4, 1965 6:45 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  3604 B Monterey Rd. Baltimore, Md., 21218				A. STATE Md.			
				B. COUNTY			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3604 B Monterey Road			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
female	white	married	Dec. 11, 1895	69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Saleslady		Stewart & Co.		Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Garrett				Sarah Connelly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		215-03-2492		Edward S. Starkloff, husband, above			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  420.1 I Coronary Occlusion Few minutes				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				5 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1960 19 to May 19 65, that (I) (we) last saw the deceased alive on April 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  Loy M. Zimmerman				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/5/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Loy M. Zimmerman				3202 Harford Road			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/8/65		New Cathedral Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 7 1965 Robert E. Fisher		19650200		Schimunek Funeral Home, Inc.		3331 Brehms Lane	

STATE OF NEW YORK

IN SENATE

January 11, 1907

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A

RESOLUTION PASSED

AT THE SENATE CHAMBERS, ALBANY, JANUARY 11, 1907.

ALBANY:

WATKINS & COMPANY, PRINTERS.

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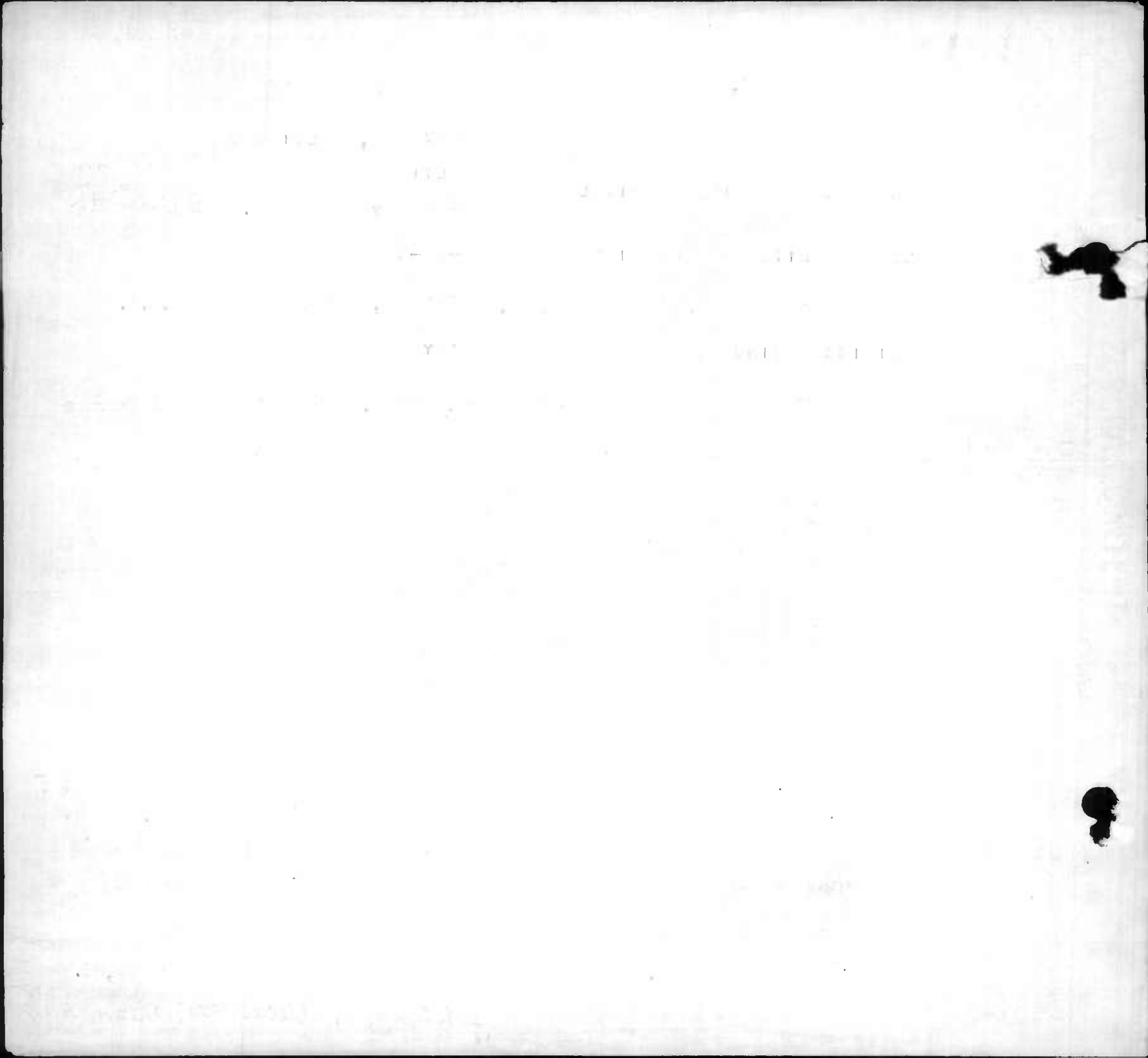
WATKINS & COMPANY, PRINTERS.

ALBANY, N. Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

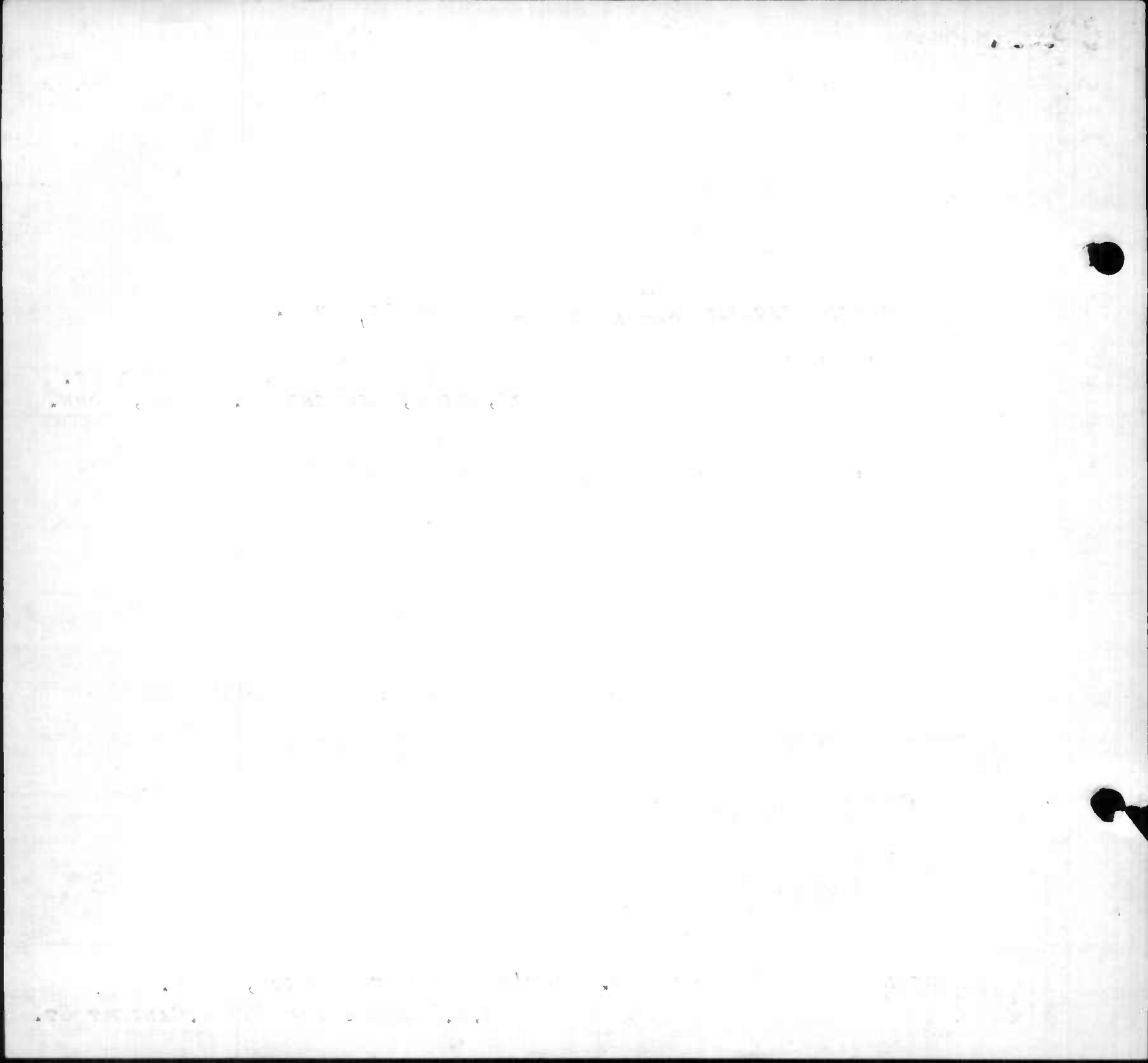
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4851</u>	
BIRTH NO. <u>65 4851</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Joseph A. Aquino</u>		2. DATE AND HOUR OF DEATH <u>5/5/65</u> <u>7<sup>10</sup></u> <u>P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <u>3 THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> , B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE Zone 6</u> D. STREET ADDRESS (If rural, give location) <u>5525 DAYBREAK TERR. DAYBREAK</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>4-14-12</u>	9. AGE (In years lost birthday) <u>52</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>J. Schoeneman Co, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>DOMINICK AQUINO</u>			14. MOTHER'S MAIDEN NAME <u>MARY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW11</u>		16. SOCIAL SECURITY NO. <u>218-01-5199</u>		17. INFORMANT ADDRESS <u>Mrs. Maria A. Aquino 5525 Daybreak Terrace</u>	
18. <u>260X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dick's mellitus</u>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> <u>1965</u> to <u>5/5</u> <u>1965</u> , that (I) (we) lost saw the deceased alive on <u>5/5</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Guio V. Segre</u>				23B. DATE SIGNED <u>5/5/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Guio V. SEGRE</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION <u>6515 Boston St-Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George A. Weber 705 South Ann</u>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4852		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4852	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HELEN L. DODD			2. DATE AND HOUR OF DEATH 5.5.65 4:52 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY CONNECTICUT		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL			C. CITY OR TOWN (If outside city limits, write RURAL and give township) WEST HAVEN		
			D. STREET ADDRESS (If rural, give location) 156 CONNECTICUT AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 2-24-04	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10B. KIND OF BUSINESS OR INDUSTRY SCHOOL SYSTEM		11. BIRTHPLACE (State or foreign country) NORWICH CONN.	
13. FATHER'S NAME THOMAS DODD			14. MOTHER'S MAIDEN NAME ABIGAIL SULLIVAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 1287 CHAPEL ST. COX, SMITH, CRIMMINS W. HAVEN, CONN.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) DUE TO Cerebral Hemorrhage Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 12 hours		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-4-65 19 to 5-5-65 19, that (I) (we) lost saw the deceased alive on 5-5-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James F. Fries				23B. DATE SIGNED 5.5.65	
23C. PHYSICIAN'S NAME (Type) JAMES F. FRIES				23D. ADDRESS JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/8/65		24C. NAME OF CEMETERY or CREMATORY OLD ST. MARY'S CEMETERY NORWICH, CONN.	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR H.W. MEARS & SON 805 N. CALVERT ST.			

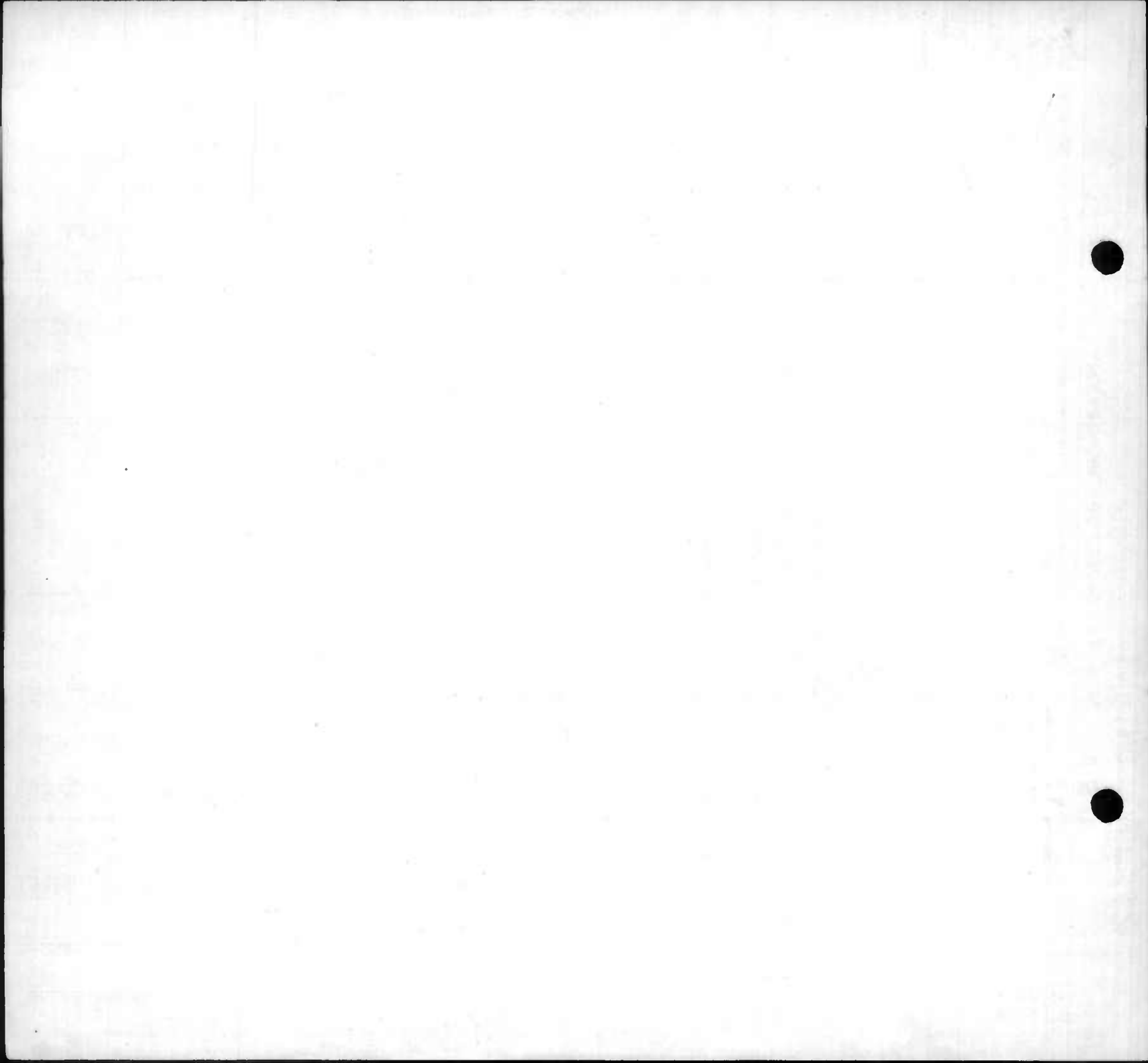




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

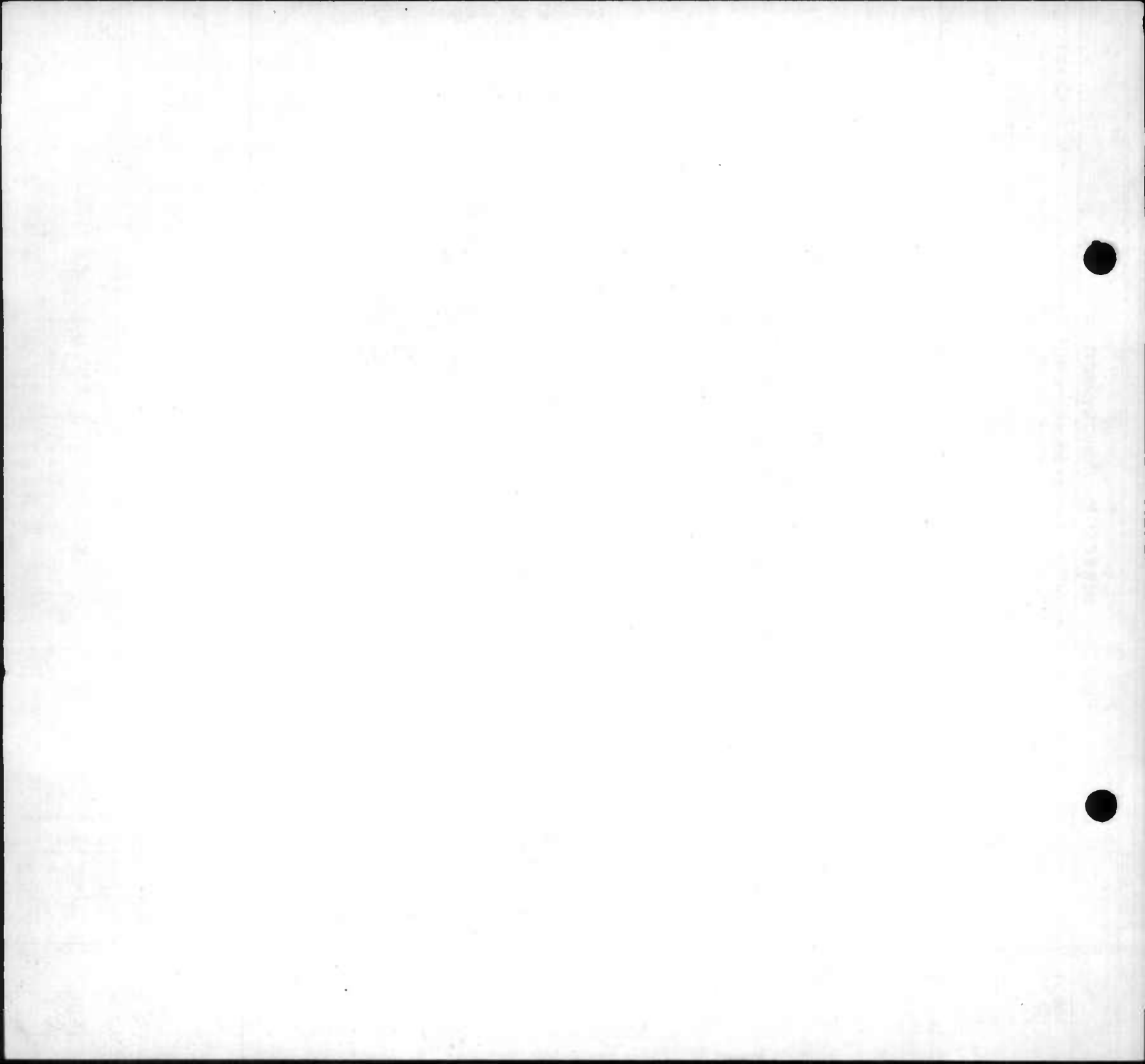
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4853</b>	
BIRTH NO. <b>65 4853</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>May 4, 1965</b> <b>1</b> P. <b>1</b> M.			
1. NAME OF DECEASED (Type or Print) <b>Goldye H. Brown</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>D. O. A. Union Memorial Hosp.</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2828 N. Calvert Street</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>Dec. 23, 1885</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Luther E. Harn</b>		14. MOTHER'S MAIDEN NAME <b>Ida O. Lease</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-3903</b>		17. INFORMANT <b>Mrs. Ida O. Oats Sister</b> <b>615 W. 23 St. Balto. Md. 21218</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Chronic Myocarditis months?</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21, 1964</b> to <b>May 4, 1965</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Frank N. Ogden</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED <b>May 6, 1965</b>		23C. PHYSICIAN'S NAME (Type) <b>Frank N. Ogden</b>		23D. ADDRESS M.D. <b>2701 N. Calvert</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b>		25D. ADDRESS <b>5209 York Road</b>		25E. ADDRESS <b>4-8-65 Funeral Home Baltimore, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <u>65 4854</u>	
BIRTH NO. <u>65 4854</u>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>August Kruehle</u>		2. DATE AND HOUR OF DEATH <u>May 3 1965</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>9404</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 Gould Nur Home</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u>			
				D. STREET ADDRESS (If rural, give location) <u>673 E 3rd St. (18)</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>5/12/</u>	9. AGE (In years last birthday) <u>52</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CABINET MAKER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>SUN CAB</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Fred.</u>			14. MOTHER'S MAIDEN NAME <u>Emma F. Thomas</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>218-074</u>		17. INFORMANT <u>Wife</u>		ADDRESS <u>Same</u>
18. <u>163 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Lung with widespread metastatic disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>—</u>				(A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Two months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>—</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> 19 <u>63</u> to <u>5/3</u> 19 <u>65</u> , that (H) (we) last saw the deceased alive on <u>5/3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Herman Brecher</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/5/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>HERMAN BRECHER</u>				23D. ADDRESS <u>443 E. 25th St. Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/5/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Immanuel</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>P. A. Hermann</u>		ADDRESS <u>6067 Hart Rd</u>	



1

65 4855

BALTIMORE CITY HEALTH DEPARTMENT

65 4855

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELIZABETH HANLIN

2. DATE AND HOUR PRONOUNCED DEAD

April 28, 1965 3:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pikesville

D. STREET ADDRESS (If rural, give location)

6811 Camofield Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

JUNE 13, 1884

9. AGE (In years  
last birthday)

80

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HAIR DRESSER

10B. KIND OF BUSINESS OR INDUSTRY

Self. Emp.

11. BIRTHPLACE (State or foreign country)

BALTO

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James A. HAMLIN

14. MOTHER'S MAIDEN NAME

CARRY CLAYMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

216-32-9934

17. INFORMANT

RECORDS

ADDRESS

6811 Camptield Rd

18.

E903.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary Embolism

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Thrombosis of Right Popliteal Vein

(C) DUE TO

Fracture of Right Femur.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

6811 Camofield Road, Pikesville

21D. TIME OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 20 '65

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Fall to floor.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/29/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/1/65

23C. NAME of CEMETERY or CREMATORY

Parkwood

23D. LOCATION

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

MAY 7 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

P.A. Heemann

ADDRESS

6067 Hay Rd

VALLEY FORGE

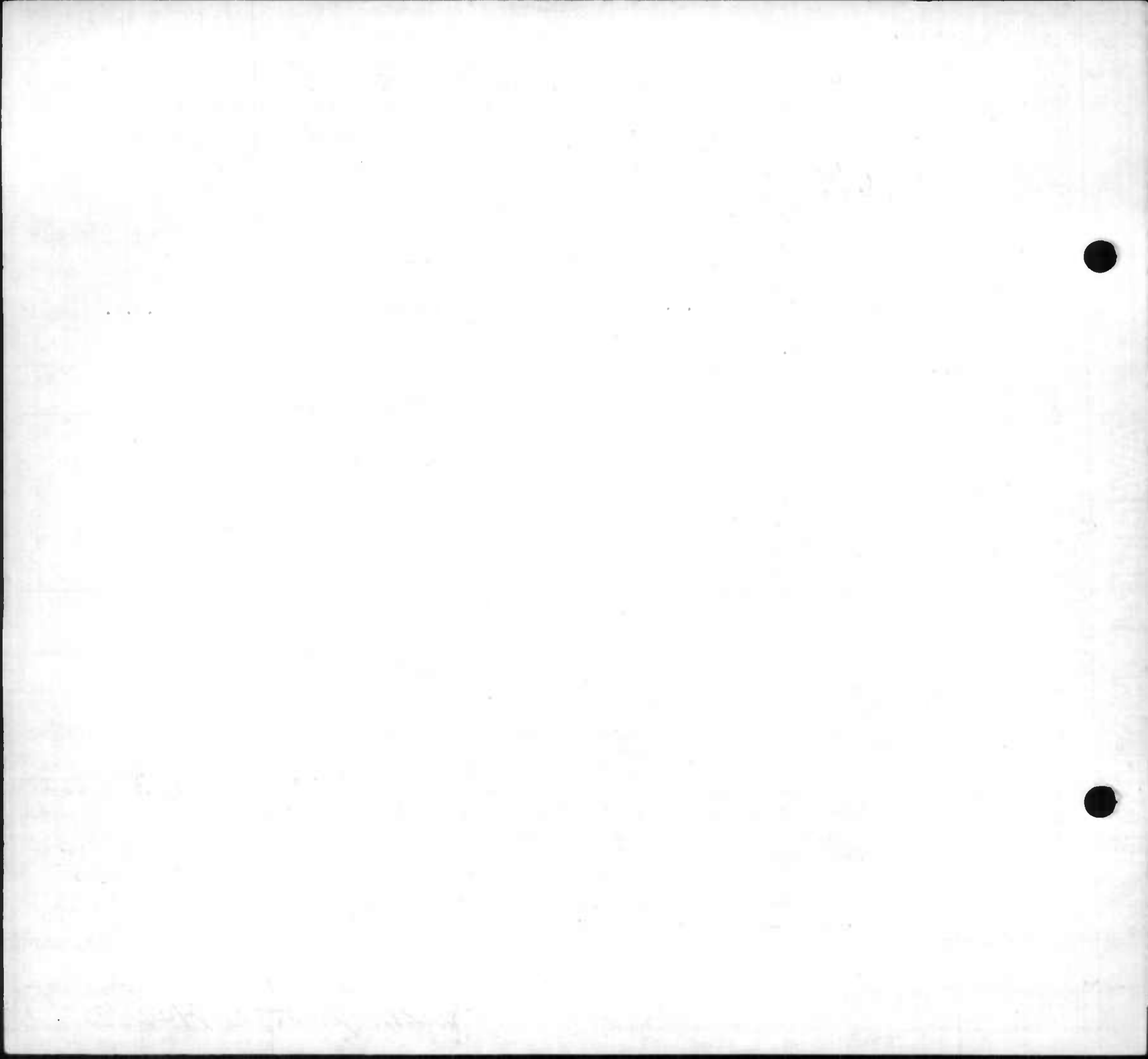
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4856	
BIRTH NO. 65 4856					
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Benjamin W. Clayton			
2. DATE AND HOUR OF DEATH		5-3-65 7 25 P M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY 401			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore City			
D. STREET ADDRESS (If rural, give location)		331 Park Ave.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 6-8-1905	9. AGE (In years last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier
10B. KIND OF BUSINESS OR INDUSTRY U.S. Employee		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. Clayton			14. MOTHER'S MAIDEN NAME Francis Ensor		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Norma Reed 3504 Bellvale Avenue 6	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Carcinoma of the Esophagus		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1962 to May 3 1965, that (I) (we) last saw the deceased alive on May 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Alfred G. Ossman Jr. M.D.				23B. DATE SIGNED 5-3-65	
23C. PHYSICIAN'S NAME (Type) Alfred G. Ossman Jr. M.D.				23D. ADDRESS 1010 St Paul St Balto 2 Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-1965		24C. NAME OF CEMETERY OR CREMATORY Sparks	
24D. LOCATION (City, town, or county) (State) M		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS			

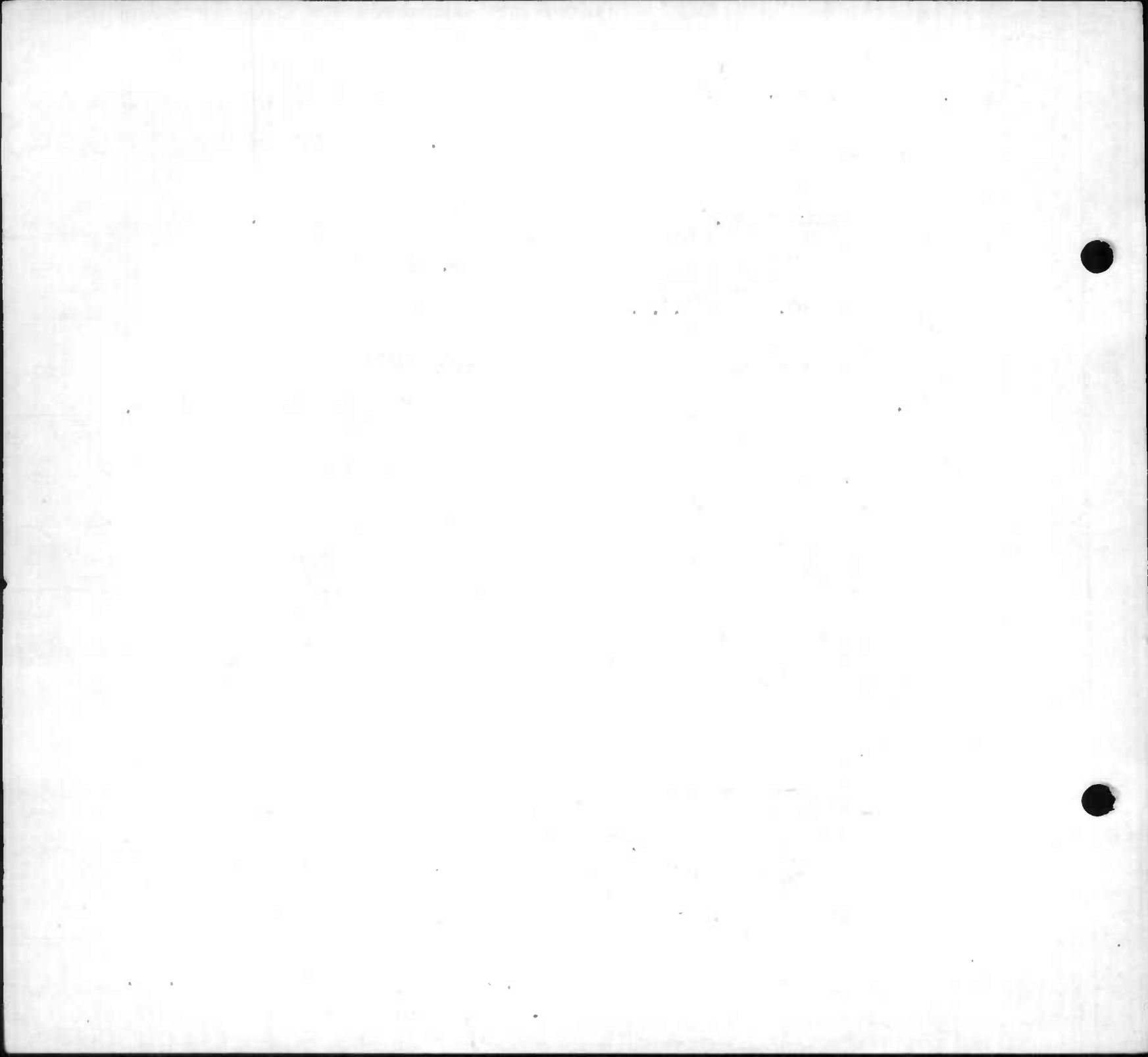




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4857</u>	
65 4857				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		Arthur G. Kendrick		May 4 1965 6:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md. Baltimore City		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
3627 Greenmount Ave.		3627 Greenmount Ave.		D. STREET ADDRESS (If rural, give location)	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
M	W	M	Mar. 24 1891	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Machinist Ret.		P.R.R.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William Kendrick		Annie Bowie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.		7I7-07-7I07		Mrs David Smith I3I4 Rosewick Ave. 6	
18. 4-20-1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Acute myocardial infarction 10 min.			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO			
ANTECEDENT CAUSES		(B) Hypertension 10 yrs.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO			
		(C) Arteriosclerotic cardio-vascular disease 10 yrs.			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 7, 1963 to May 4, 1965, that (I) (we) last saw the deceased alive on April 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Lloyd E. Saylor				May 6, 1965	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Lloyd E. Saylor		M.D. 3902 Greenmount Ave. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/7/65		Cedar Hill Cem.	
				Prince Georges Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 7 1965		Robert E. Fairbank		Lassahn Funeral Home 7401 BELAIR RD.	



BIRTH NO. 65-02216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>FRANCINE MITCHEL</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>May 4, 1965</b> <b>7:50 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>ST. JOSEPH HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____ C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1309 Ensor Street</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>2-1-65</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>3</b>
13. FATHER'S NAME <b>Rufus Mitchel</b>		14. MOTHER'S MAIDEN NAME <b>Annabelle Stokes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Rufus Mitchell 1309 Ensor ST</b>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Interstitial pneumonitis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>John E. Adams</u> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>John E. Adams, M.D.</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>5-4-65</b>			
23A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23B. DATE <b>5/7/65</b>	23C. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY</b>
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	24C. FUNERAL DIRECTOR ADDRESS <b>Joseph G. Locks Jr 1304 N. Central</b>

WALKLEY POLICE

REPORT

UNIT

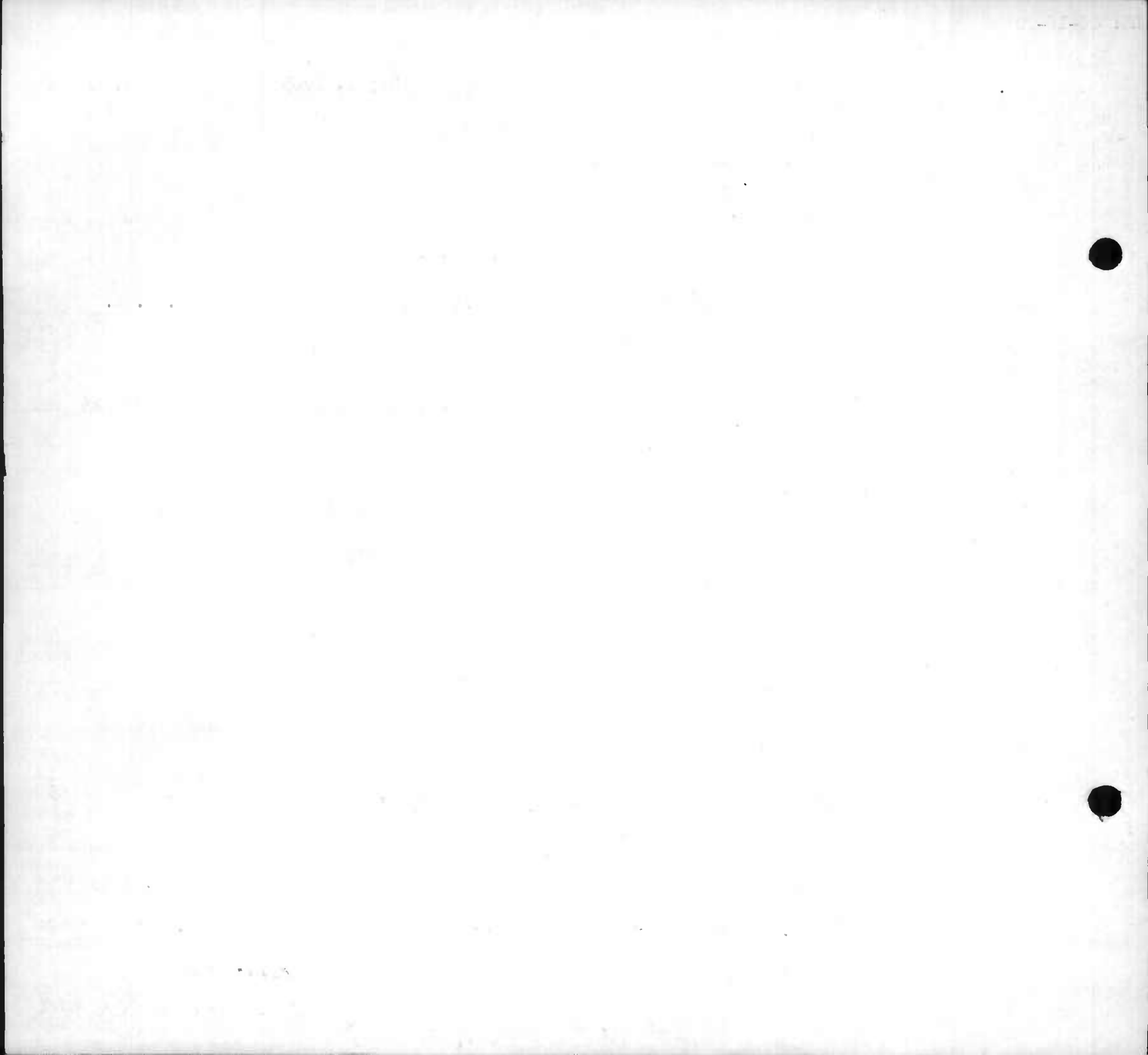
LS: 26-16-20

5-000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4859	
BIRTH NO. 65 4859		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Alice Mary Shay			
2. DATE AND HOUR OF DEATH		May 6, 1965 7:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 26-12			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		D. STREET ADDRESS (If rural, give location) 4940 Eastern Avenue #21224			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 11-2-85	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Henry Norris		14. MOTHER'S MAIDEN NAME Marie Barnes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war & dates of service) No No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24	
18. 352X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Sepsis DUE TO (B) Acute + Chronic Pyelonephritis DUE TO (C) Decubiti Ulcers			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II Paraplegia Etiology Unknown			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 27, 1959 to May 6, 1965, that (I) (we) last saw the deceased alive on May 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Philip Zieve		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED May 6, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Philip Zieve		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/9/65		24C. NAME OF CEMETERY or CREMATORY Bethel Meth. Ch. Cemetery	
24D. LOCATION Rively - VA.		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Thomas J. Kenny Inc. Balto Md			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 4860</span>						
BIRTH NO. <span style="font-size: 1.2em;">65 4860</span>					M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Anna R. Chesonis</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">May 5th 1965</span>						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.1em;">Melchor Nursing Home 2327 N. Charles St.</span>					A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">25-05</span>						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.1em;">Baltimore</span>						
					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.1em;">1315 Cambria St.</span>						
5. SEX <span style="font-size: 1.1em;">Female</span>	6. RACE <span style="font-size: 1.1em;">wh</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <span style="font-size: 1.1em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">8-8-1885</span>	9. AGE (In years last birthday) <span style="font-size: 1.1em;">79</span>	If Under 1 Yr. Months: Days: Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">SEAMSTRESS</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">TAILORING</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Lithuania</span>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Ramanasukas</span>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">no</span>			16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">216-051462</span>		17. INFORMANT <span style="font-size: 1.1em;">Joseph Chesonis 1006 Plover Dr. Balto 27</span>				ADDRESS		
18. <span style="font-size: 1.2em;">420.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <span style="font-size: 1.1em;">ARTERIOSCLEROTIC HEART DISEASE</span> DUE TO (B) <span style="font-size: 1.1em;">Generalized Arteriosclerosis</span> DUE TO (C) _____					INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">Indefinite</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<span style="font-size: 1.1em;">Cerebral Arteriosclerosis</span>					<span style="font-size: 1.1em;">Indefinite</span>	
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">25 APRIL 1965</span> to <span style="font-size: 1.1em;">5 MAY 65</span> 19 that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">5 MAY 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <span style="font-size: 1.1em;">John B. DeHoff, M.D.</span>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.1em;">6 May 65</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">John B. DeHoff, M.D.</span>					23D. ADDRESS <span style="font-size: 1.1em;">1701 Meridene Drive Balto. 12, Md.</span>						
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">5-8-1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.1em;">Holy Redeemer Cem</span>		24D. LOCATION <span style="font-size: 1.1em;">Balto. Md.</span>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">MAY 7 1965</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">P. L. E. F. J. J. J.</span>			25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Thos. J. Henry, Inc 1500 Hollins Balto.</span>			ADDRESS		





65 4861

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 4861

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPHINE HERRMAN

2. DATE AND HOUR OF DEATH

XXXXXX 5-4-65 10.45 P M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

4300 FURLEY AVENUE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

1-15-85

9. AGE (In years  
last birthday)

80

If Under 1 Yr.  
Months OaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEORGE QUICK

14. MOTHER'S MAIDEN NAME

EMMA DANZ

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Thelma Urban 5816 Heron Drive

18.

4341 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebrovas. accident (left)

3 days

ANTECEDENT CAUSES

(B) Congestive Heart failure

months

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 5/1 19 65 to 5/4 19 65  
that (1) (we) last saw the deceased alive on 5/4 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W.C. MADDREY

M.O.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5/4/65

23C. PHYSICIAN'S  
NAME (Type)

W.C. MADDREY

M.O.

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/8/65

24C. NAME OF CEMETERY or CREMATORY

Jerusalem Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY

7 1965

25B. NAME OF REGISTRAR

R. E. F. F. F.

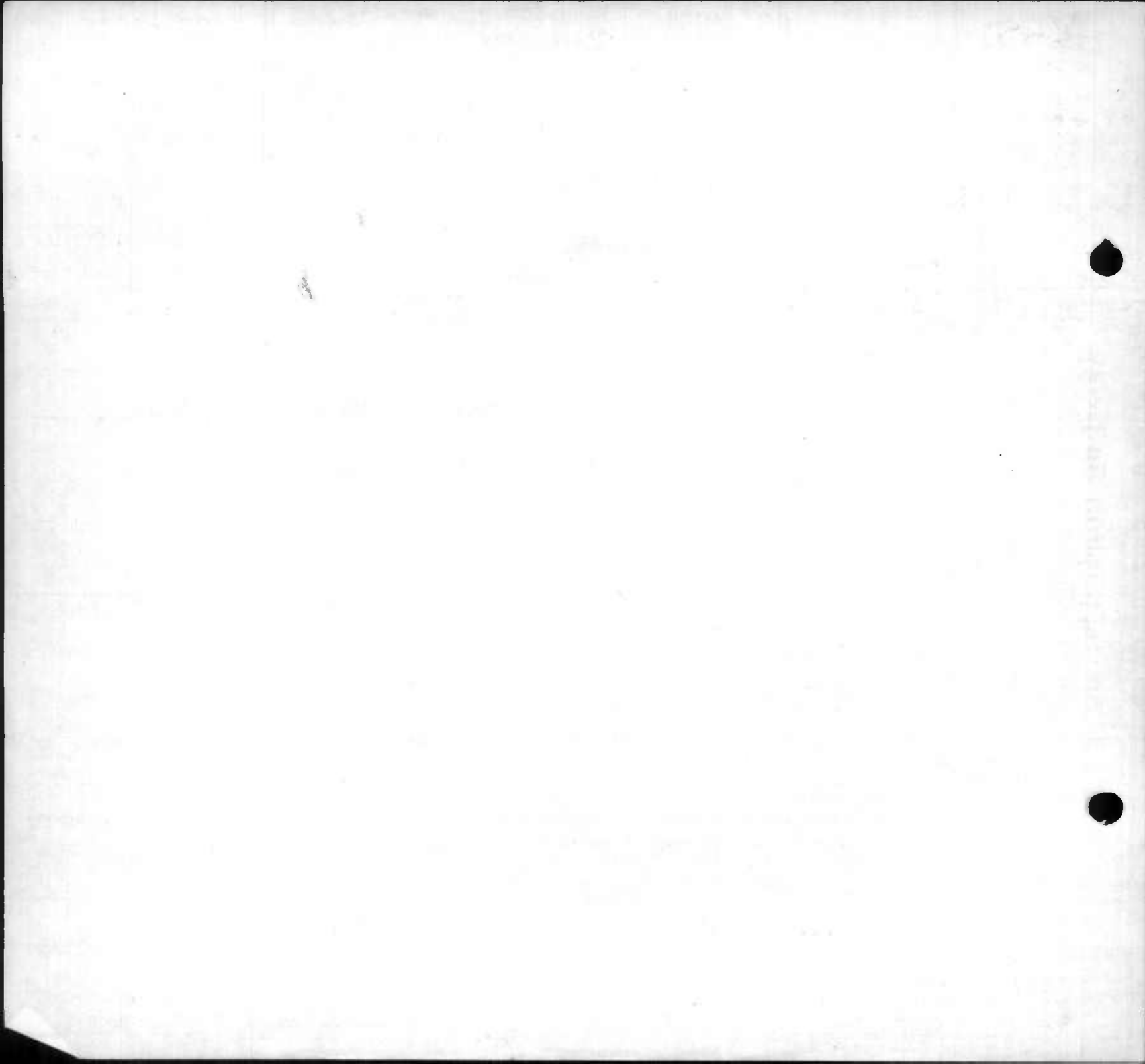
25C. FUNERAL DIRECTOR

Ulrich Funeral Home 4210 Belair Road

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

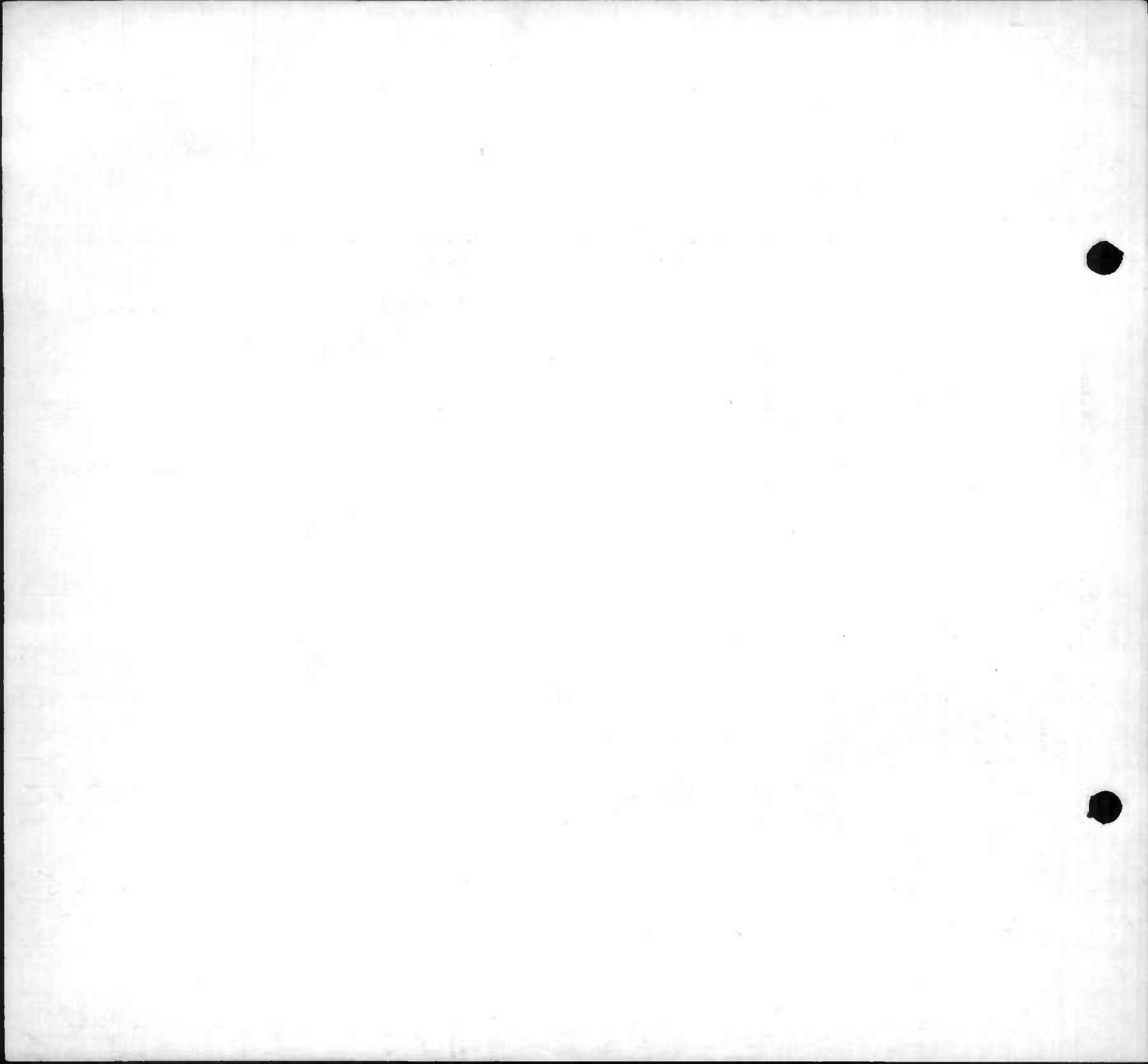
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4862					65 4862				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
ROBERT H. WILSON					May 5, 1965 7 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION  4134 Parkside Drive					A. STATE Maryland				
(If not in hospital or institution, give street address or location)					B. COUNTY 27-01				
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
Baltimore					4134 Parkside Drive				
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH Nov. 14, 1899		9. AGE (In years last birthday) 65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Howard Lee Wilson					14. MOTHER'S MAIDEN NAME Carrie Heisse				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1					16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elizabeth Wilson 4134 Parkside Drive		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  1539 I Metastatic CARCINOMA Adeno carcinoma of Bowel  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH Metastatic CARCINOMA Adeno carcinoma of Bowel			INTERVAL BETWEEN ONSET AND DEATH Sudden	
19. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from JAN 28 1964 to MAY 5 1965, that (I) (we) lost saw the deceased alive on MAY 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Milton J. Wohl					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED 5-6-65	
23C. PHYSICIAN'S NAME (Type) Milton H. Wohl, M.D.					23D. ADDRESS M.D. 3000 Brendan Ave.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			25B. NAME OF REGISTRAR Robert E. Farley, M.D.			25C. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.			ADDRESS



1

65 4863

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4863

BIRTH NO. M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ISAAH HARVEY

2. DATE AND HOUR PRONOUNCED DEAD May 5, 1965 4:59 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE 8. DATE OF BIRTH 6-18-1938 9. AGE (In years last birthday) 27 26 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUCKSTER 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLIE H. HARVEY 14. MOTHER'S MAIDEN NAME ANNA E. BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO. 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS JOHN HARVEY 1632 NORMAL AVE

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty Liver and Cirrhosis. (A) DUE TO (B) DUE TO (C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [ ]

EXAMINER'S NAME (Type) Charles S. Petty, M.D. DATE SIGNED 5/6/65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL 23B. DATE 5-10-65 23C. NAME OF CEMETERY or CREMATORY MT CALVARY 23D. LOCATION (City, town, or county) (State) A.A. COUNTY MD.

24A. DATE REC'D BY HEALTH DEPT. MAY 7 1965 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. 24C. FUNERAL DIRECTOR ADDRESS JOSEPH KNIGHT 1639 N. BROADWAY

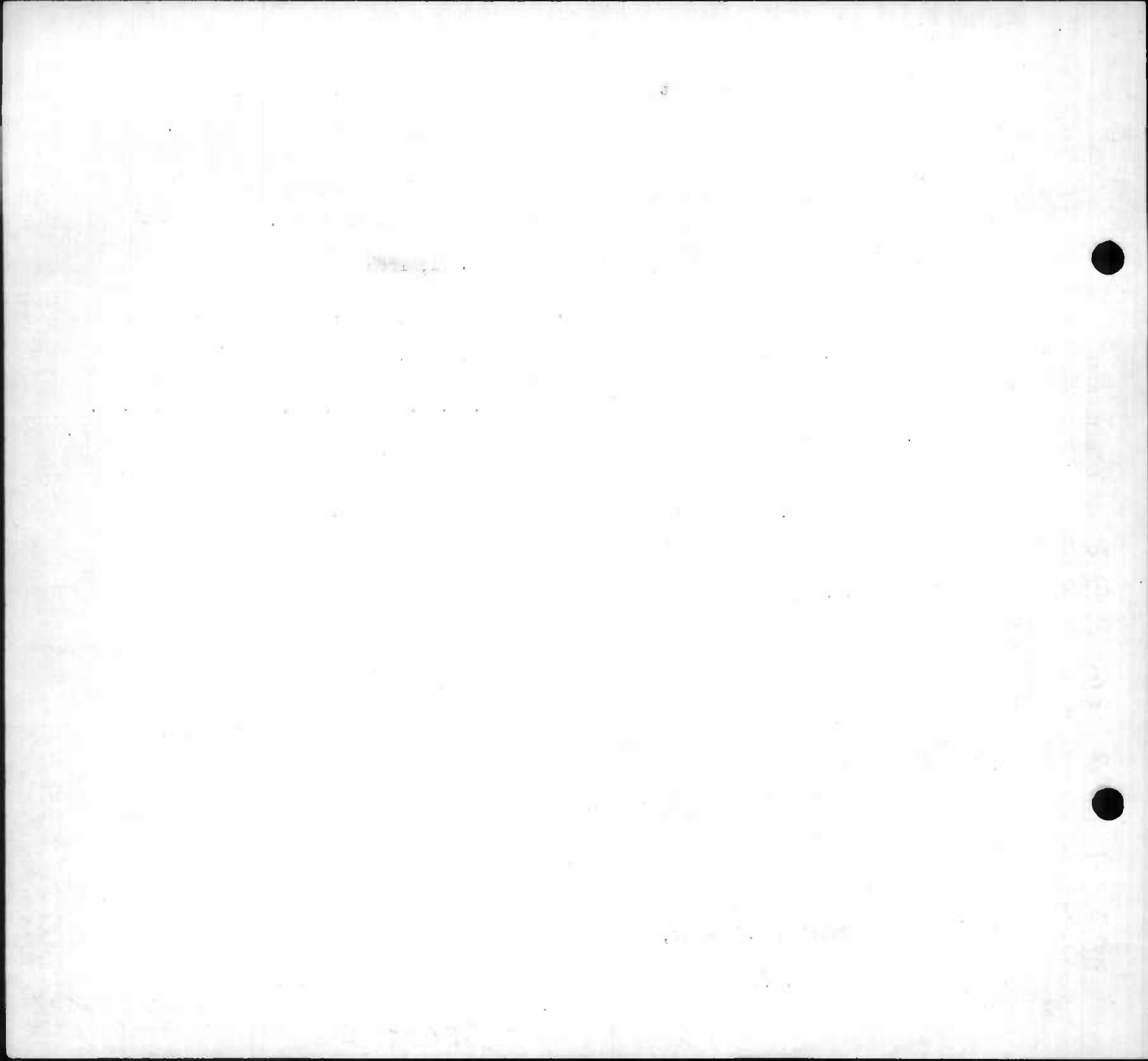
VS 151-REV. 1/1/65

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4864</u>	
BIRTH NO. <u>65 4864</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Edna Florence Newton</u>		2. DATE AND HOUR OF DEATH <u>May 5, 1965</u> <u>4:40 A.M.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>3502 Clifton Avenue Clifton Nursing Home</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>5644 Woodmont Ave.</u> <u>21212</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>Aug. 31, 1884</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Electrolux Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Charles P. Newton</u>			14. MOTHER'S MAIDEN NAME <u>Clara M. White</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Forge Lane</u> <u>Mr. H. P. Newton, Jr. Irvington, N. Y.</u>	
18. <u>540.01</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Congestion heart failure 2 days</u> DUE TO			
ANTECEDENT CAUSES		(B) <u>Hemorrhagic peptic ulcer one week</u> DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<u>0</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-12</u> 19 <u>64</u> to <u>May 5,</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 4,</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Maurice E. Shamer</u> M.D.				23B. DATE SIGNED <u>May 7, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Maurice E. Shamer</u>				23D. ADDRESS <u>3300 W. North Ave.</u> <u>Baltimore 16, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/8/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>	
24D. LOCATION <u>Woodlawn, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u>		25C. FUNERAL DIRECTOR <u>Wm. J. Johnson &amp; Sons</u> <u>Baltimore, Md. 17</u> <u>North Ave.</u>	

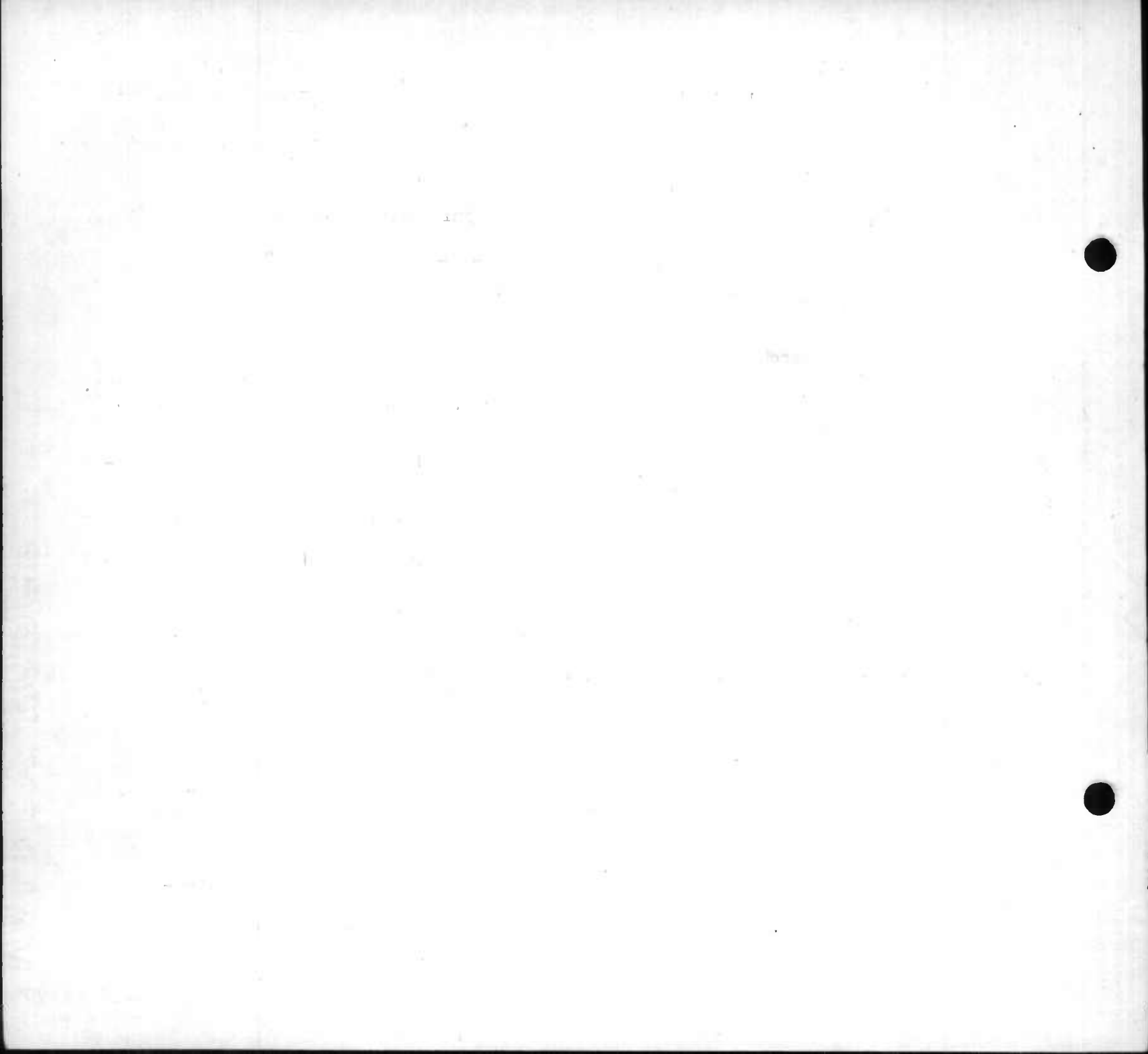




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4865</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4865</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">MC CALL, LILLIAN</span>			5-6-65 12:20PM M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</span>			A. STATE <span style="font-size: 1.1em;">MARYLAND</span>		
			B. COUNTY <span style="font-size: 1.2em;">25-04</span>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
<span style="font-size: 1.1em;">BALTIMORE</span>			<span style="font-size: 1.1em;">3618 Saint Victor Street</span>		
5. SEX <span style="font-size: 1.1em;">F</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.1em;">WIDOW</span>	8. DATE OF BIRTH <span style="font-size: 1.1em;">9-21-82</span>	9. AGE (in years last birthday) <span style="font-size: 1.1em;">82</span>	10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Homemaker</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Baltimore, Maryland</span>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <span style="font-size: 1.1em;">LEONARD Fetsch</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">ANNA RAPP</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.1em;">Mrs. Vivian Robertson</span>
18. <span style="font-size: 1.2em;">121X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.1em;">UREMIA</span> DUE TO (B) <span style="font-size: 1.1em;">RENAL FAILURE</span> DUE TO (C) <span style="font-size: 1.1em;">CARCINOMA CERVIX</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">5-2-65</span>  <span style="font-size: 1.1em;">SINCE 5-2-65</span>  <span style="font-size: 1.1em;">SINCE 1-64</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<span style="font-size: 1.1em;">PULMONARY EMPHYSEMA</span>		
19A. DATE OF OPERATION <span style="font-size: 1.1em;">4-26-65</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.1em;">CARCINOMA OF CERVIX</span>		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">4-19-65</span> 19 to <span style="font-size: 1.1em;">5-6-65</span> 19, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">5-6-65</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Stephen Kranz</span>				23B. DATE SIGNED <span style="font-size: 1.1em;">5-6-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">STEPHEN M. KRANZ</span>				23D. ADDRESS <span style="font-size: 1.1em;">JOHNS HOPKINS HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">5/8/1965</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Loudon Park Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Maryland</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.1em;">MAY 7 1965</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">G. E. Farkas</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">Wm. F. Tipton &amp; Sons</span>			
25D. ADDRESS <span style="font-size: 1.1em;">Baltimore, Md. 21217</span>		25E. ADDRESS <span style="font-size: 1.1em;">North Ave.</span>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

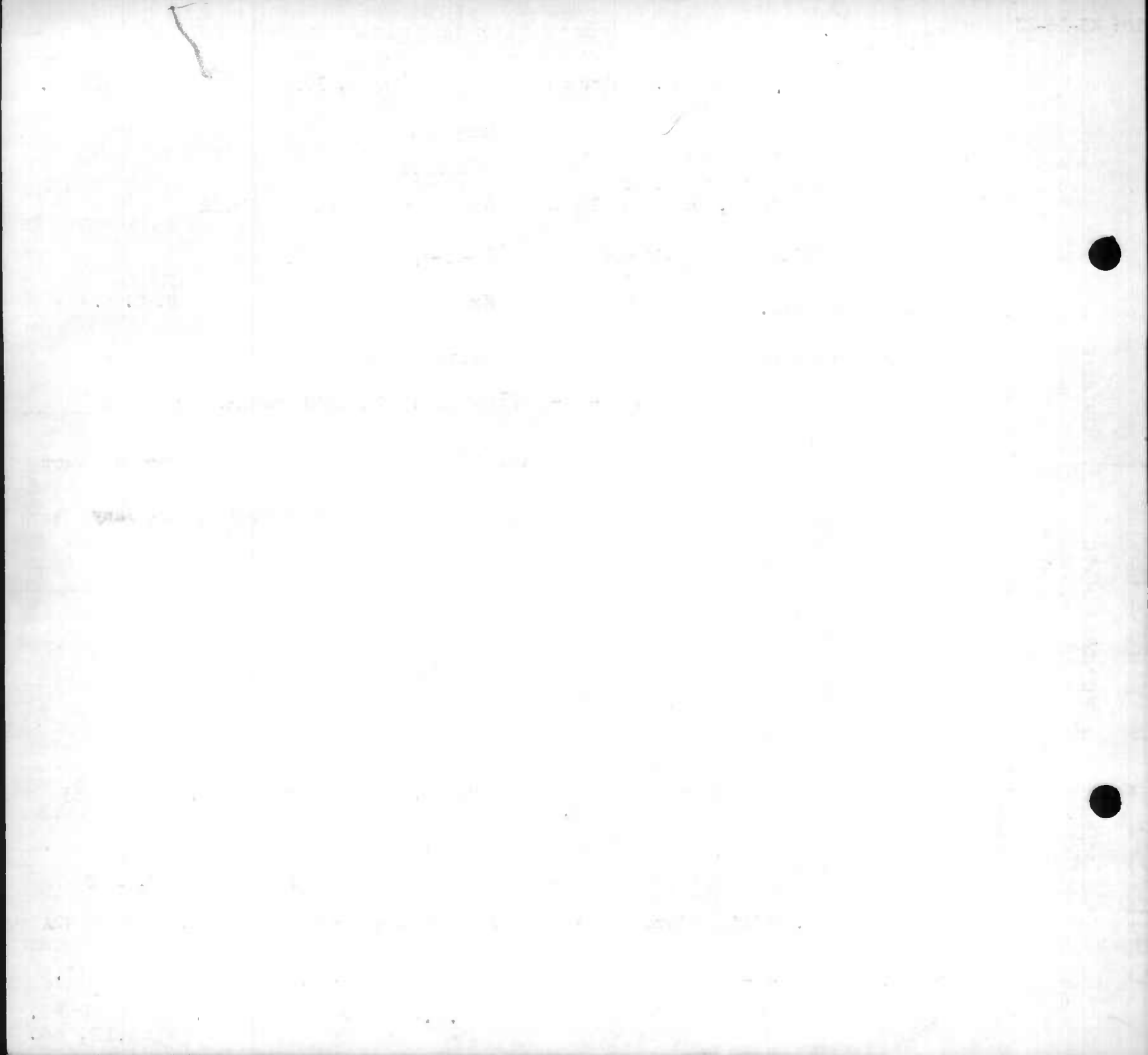
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 4866</u>				
BIRTH NO. <u>65 4866</u>									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Helen R. Zorzi</u>					2. DATE AND HOUR OF DEATH <u>5-6-65</u> <u>250</u> A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 Union Memorial Hospital</u> <u>Baltimore 18 Md</u>					A. STATE <u>Maryland</u> B. COUNTY <u>27-38</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore -12</u>				
					D. STREET ADDRESS (If rural, give location) <u>5618 Woodmont Ave</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>5-9-00</u>	9. AGE (In lost birth) <u>64</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CWN HOME</u>		11. BIRTHPLACE (State or foreign coun) <u>WILKES-BARRE, PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM E. ROBINSON</u>					14. MOTHER'S MAIDEN NAME <u>BLANCHE CARMAN</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>199-12-6176A</u>		17. INFORMANT <u>WILLIAM F. ZORZI, 5421 WILLOWMERE WAY</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> <u>HAS CVD</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>5-6-65</u> to <u>5-6-65</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>5-6-65</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <u>Alfred H. Ossman Jr</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>5-6-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alfred G Ossman Jr</u>					23D. ADDRESS <u>1010 St Paul St Balto 2 Md</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>			25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</u>			

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A-265  
 LS: 43-46-22  
 1  
 This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

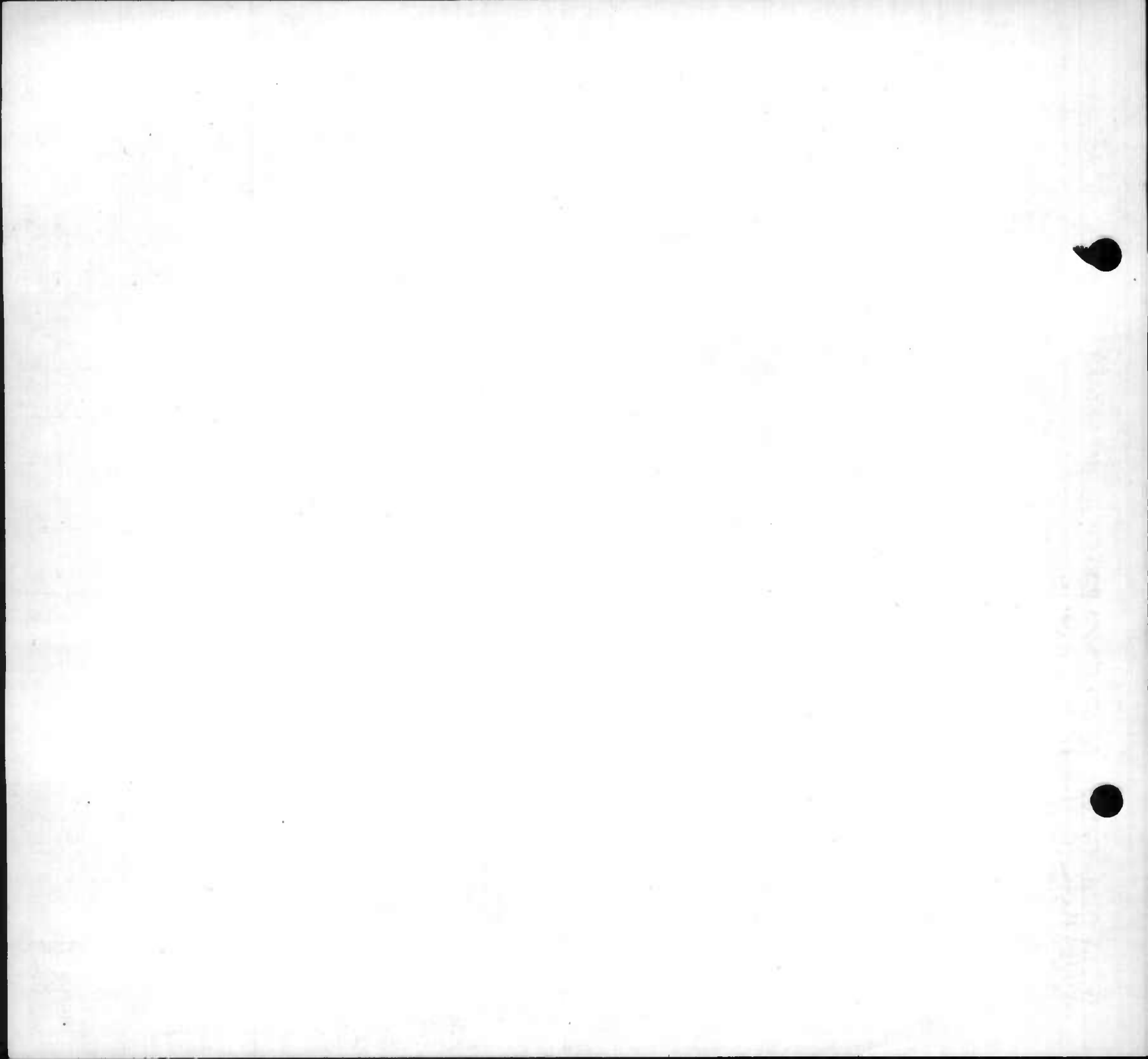
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4867	
BIRTH NO. 65 4867				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>A. Raymond Ackerman</b>				May 5, 1965 9:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
				D. STREET ADDRESS (If rural, give location) <b>6300 Boxwood Road #21212</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12-13-79</b>	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (Ret.)</b>			11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Edward Ackerman</b>			14. MOTHER'S MAIDEN NAME <b>Susan Watson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>270-09-5345</b>		
17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #24</b>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>Several Hours</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease Many Years</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>April 29, 1965</b> to <b>May 5, 1965</b> , that (H) (we) last saw the deceased alive on <b>May 5, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Philip Zieve</i> M.D.				23B. DATE SIGNED <b>May 5, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Philip Zieve</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>5-6-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Green Mount</b>	
		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Felt</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <b>65 4868</b>	
BIRTH NO. <b>65 4868</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CARL E. TAZEN</b>		2. DATE AND HOUR OF DEATH <b>5-6-65 7:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-06</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE #16</b>			
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <b>2642 W. LAFAYETTE</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>10-26-14</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>East Orange New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Tazen</b>			14. MOTHER'S MAIDEN NAME <b>Esther Tyler</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>230-01-8588</b>			17. INFORMANT <b>LoRRINE TAZEN</b>				ADDRESS <b>2642 LAFAYETTE Ave</b>
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SUBARACHNOID HEMORRHAGE</b>				INTERVAL BETWEEN ONSET AND DEATH			
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-2</b> 19 <b>65</b> to <b>5-6</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5-6</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jesusa G. Santiana</b> M.D.				23B. DATE SIGNED <b>5-6-65</b>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS <b>LUTHERAN HOSPITAL OF Md</b>				23E. FUNERAL DIRECTOR <b>Joseph E. Burns</b>		ADDRESS <b>2642 W. LAFAYETTE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus (Baltimore) Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink</b>		25C. FUNERAL DIRECTOR <b>Joseph E. Burns</b>		ADDRESS <b>2642 W. LAFAYETTE</b>	



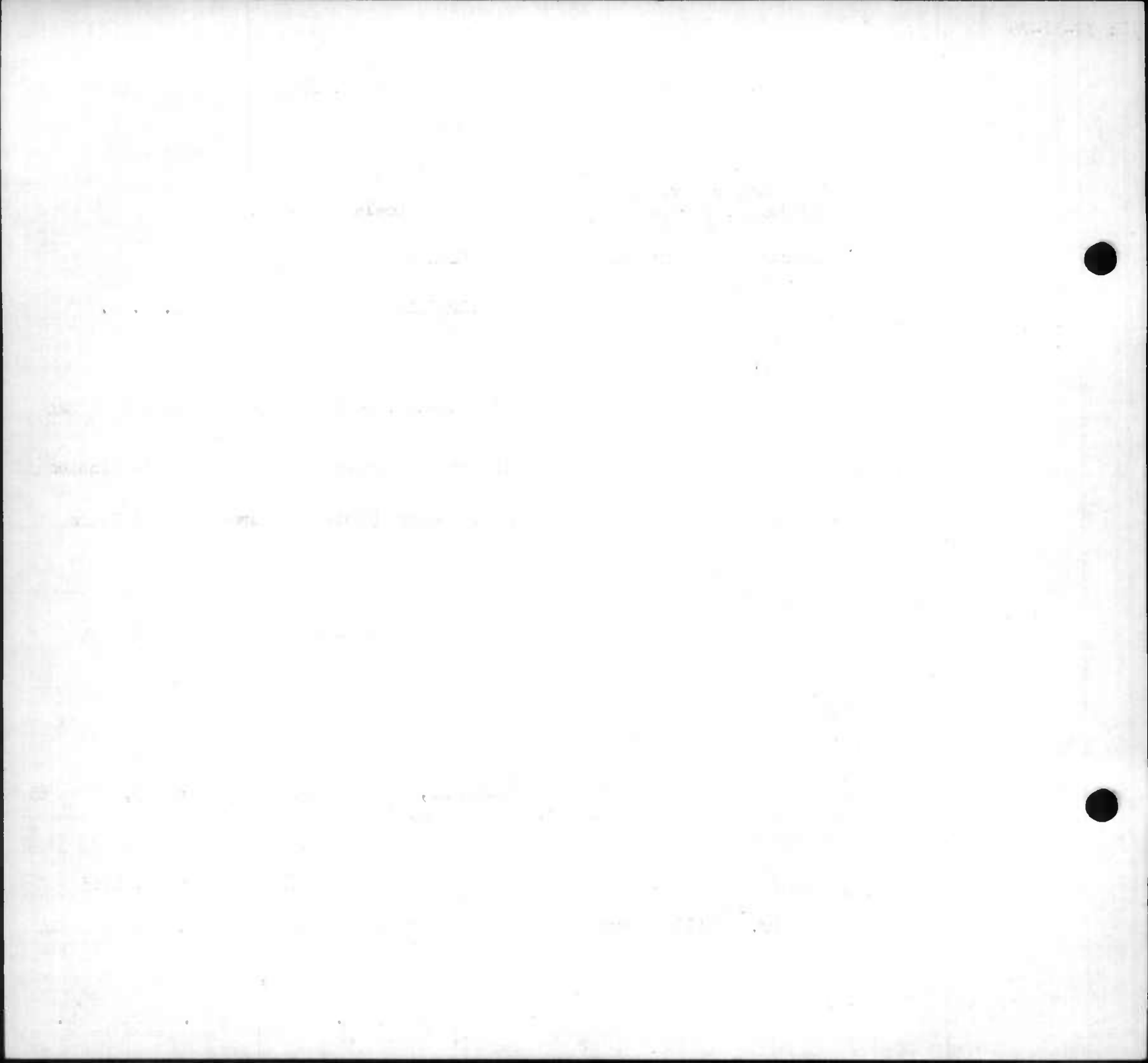


IS: 37-31-76

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4869	
BIRTH NO. 65 4869		M.E. CASE NO.		C-462	
1. NAME OF DECEASED (Type or Print) <b>Lula Clark</b>			2. DATE AND HOUR OF DEATH <b>May 4, 1965 10:30 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #24</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>15-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2320 Ocala Avenue</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6-9-96</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>John Gland</b>		
14. MOTHER'S MAIDEN NAME <b>Precilla</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>233X I</b> <b>Aspiration Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Cerebral Vascular Accident</b>			19. DATE OF OPERATION <b>2</b>		
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>March 15, 19 65</b> to <b>May 5, 19 65</b> , that (I) (we) last saw the deceased alive on <b>May 5, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip Zieve</b> M.D.				23B. DATE SIGNED <b>May 5, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Philip Zieve</b>				23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/8/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION <b>Arbutus, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Faldut</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Charles A. Rice 661 W. Barre St.</b>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MAUREEN OWENS BROWN

2. DATE AND HOUR PRONOUNCED DEAD

May 5, 1965 3:32 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

112 N. Culver Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

5/5/46

9. AGE (In years  
last birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Edward R. Owens

14. MOTHER'S MAIDEN NAME

Ruth Cooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Donald Brown 112 N. Culver St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Gunshot Wound of Head.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Rest Room

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

Tavern, 2 N. Wheeler Avenue

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)  
5 5 '65 P

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot self.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/6/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/10/65

23C. NAME of CEMETERY or CREMATORY

Carver Memorial park

23D. LOCATION

City, town, or county

(State)

Muirkirk, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 7 1965

Robert E. Farkner

Charles A. Rice 661 W. Barre St.

WALLER PORTAGE

WALLER PORTAGE

WALLER

WALLER

5-5-65. RELEASED AS NON-

MED BY

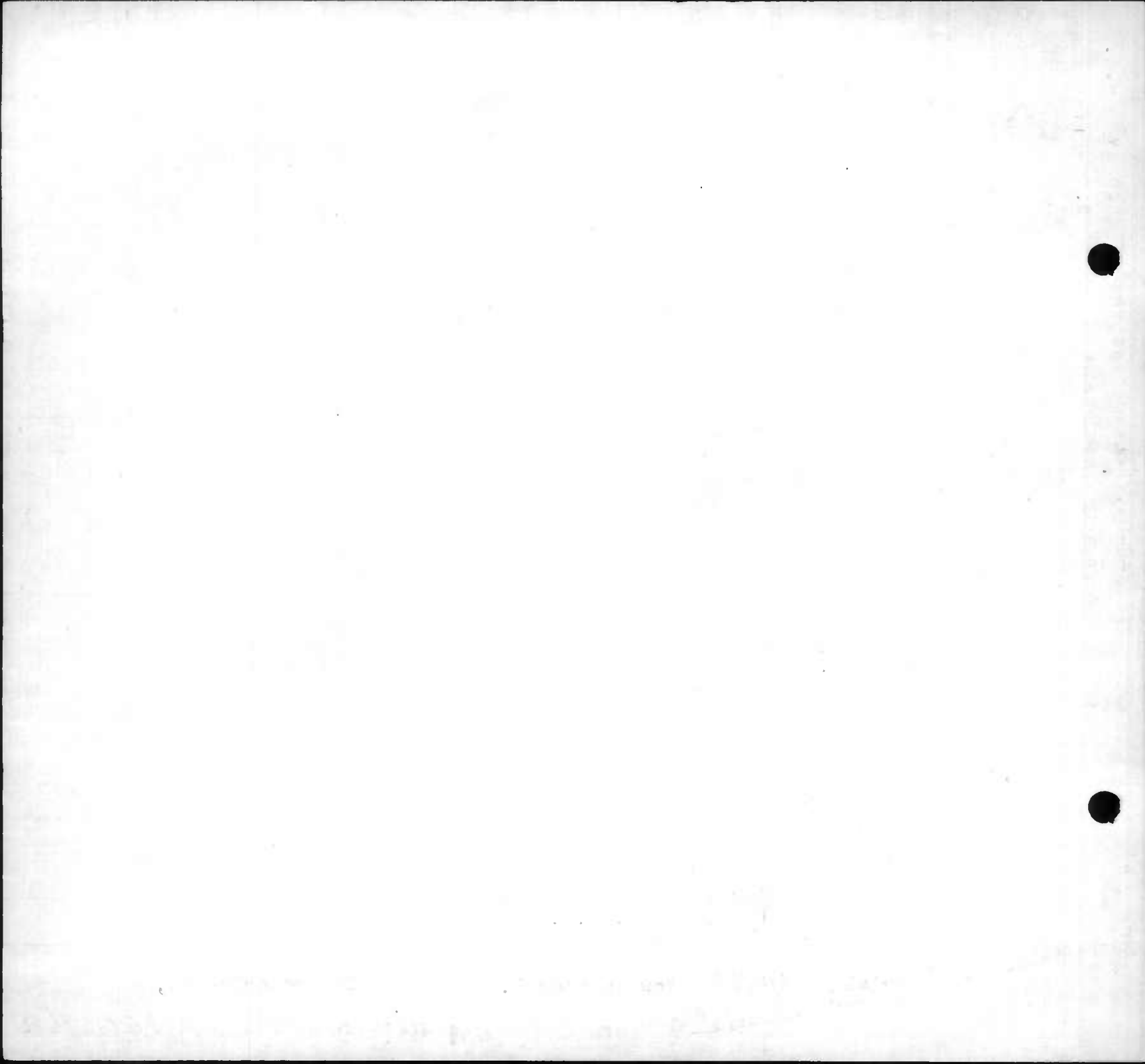
M.E.

FUNERAL DIRECTOR: IMPORTANT

DR. BREITNECKER

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

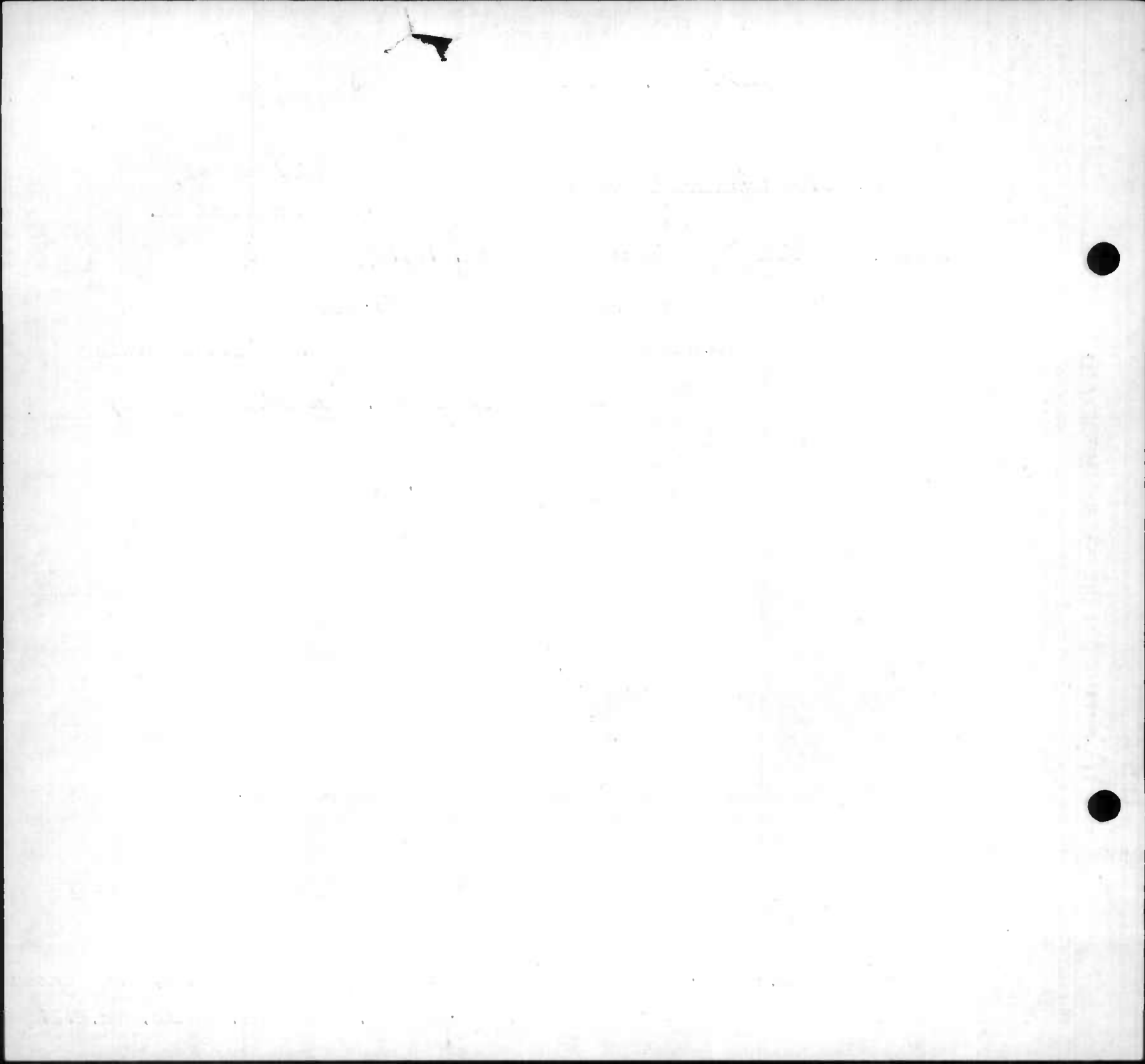
BALTIMORE CITY HEALTH DEPARTMENT									
1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <i>Katherine Clay</i>					2. DATE AND HOUR OF DEATH <i>5/5/65</i> <i>9 AM</i> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>					A. STATE <i>md.</i> B. COUNTY <i>13-07</i>				
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
D. STREET ADDRESS (If rural, give location) <i>4139 Falls Rd.</i>									
5. SEX <i>7</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i>		8. DATE OF BIRTH <i>2/27/95</i>		9. AGE (In years last birthday) <i>70</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>GEORGE BLAKERT</i>					14. MOTHER'S MAIDEN NAME <i>ANNA KAPRAN</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>					16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>ERNEST SCHROEDER-109 ROCK GLEN RD.</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.11-171X</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH <i>Myocardial infarct</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2-3 hrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO			(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					(C) DUE TO				
19A. DATE OF OPERATION <i>5/5/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma of Cervix</i>			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>2-5 yrs?</i>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>5/5/65</i> 19 <i>65</i> to <i>5/5/65</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5/5/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>DOA</i>									
23A. SIGNATURE <i>Virgil Brown</i>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>VIRGIL BROWN. M.D.</i>					23D. ADDRESS <i>M.D.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/8/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral.</i>			24D. LOCATION (City, town, or county) (State) <i>Old Frederick Rd, Md</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>			25C. FUNERAL DIRECTOR <i>Augustine E. Bonocant-3818 Roland Ave</i>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. 65 4872					CERTIFICATE OF DEATH		Registered No. 65 4872			
1. NAME OF DECEASED (Type or Print) <i>Caroline J. Keller</i>					2. DATE AND HOUR OF DEATH <i>May 6, 1965</i> <i>2:15 P.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1100 Lyndhurst Street</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>16-08</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #29</i> D. STREET ADDRESS (If rural, give location) <i>1100 Lyndhurst St.</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Dec. 18, 1877</i>	9. AGE (In years last birthday) <i>87</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>? Ostrowski</i>					14. MOTHER'S MAIDEN NAME <i>? Michaelkievoicz</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Frances J. Charewich</i>		ADDRESS <i>(Same)</i>			
18. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) <i>Serivility</i> DUE TO (B) <i>Cardio-vascular disease</i> DUE TO (C) <i>acute failure</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i> <i>5 yrs.</i> <i>3 days</i>		
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>May 3, 1965</i> to <i>May 6, 1965</i> , that (I) (we) last saw the deceased alive on <i>May 6, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>Leo E. Wells</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>5-6-65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Leo E. Wells</i>					23D. ADDRESS M.D. <i>4100 Edmondson Ave.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>5/10/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Colonial Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Hamilton Township, New Jersey</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1965</i>			25B. NAME OF REGISTRAR <i>Robert E. Fairbanks</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>			ADDRESS <i>Balto. Md. 21214</i>		

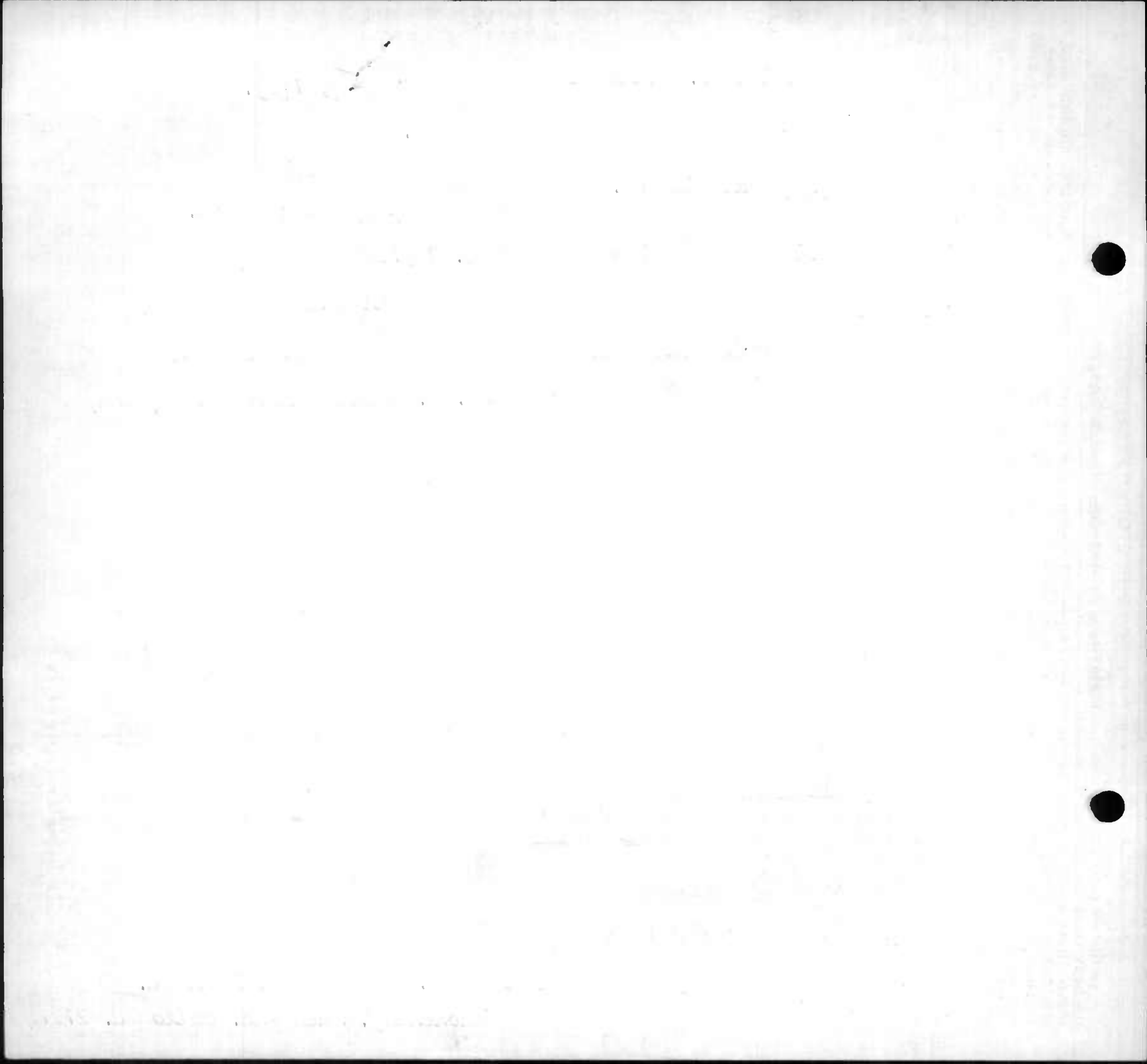




FUNERAL DIRECTOR: IMPORTANT

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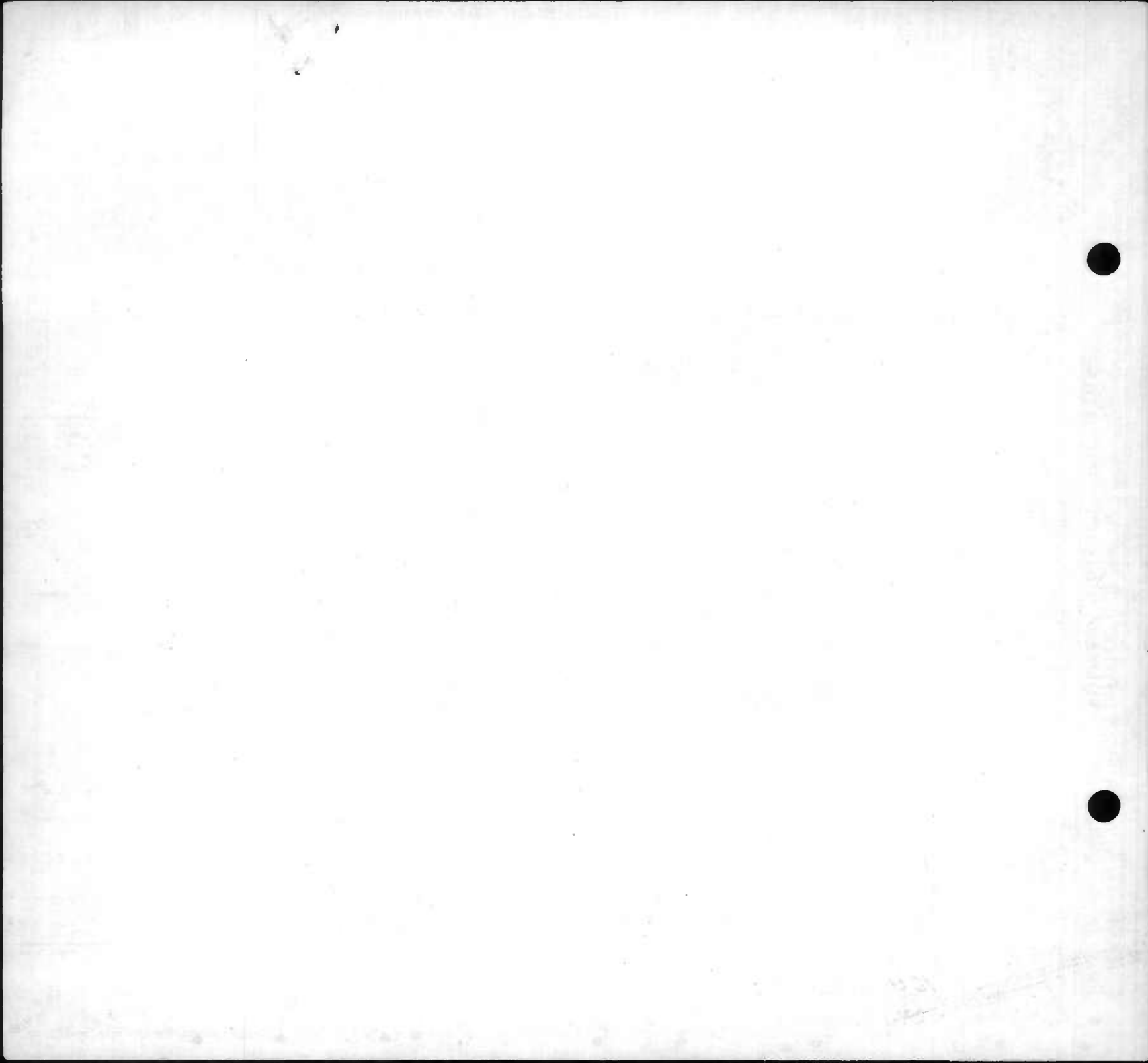
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4873					REGISTERED NO. 65 4873				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>Maurice T. Hartzell</b>					2. DATE AND HOUR OF DEATH <b>May 4, 1965</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3307 Maravia Ave.</b>					A. STATE <b>Md.</b> B. COUNTY <b>27-01</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>3307 Moravia Ave.</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Dec. 22, 1880</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>David Hartzell</b>					14. MOTHER'S MAIDEN NAME <b>Martha Dennis</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. C. Stanley Leimbach</b>		ADDRESS <b>(Same)</b>		
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>					CAUSE OF DEATH (A) DUE TO <b>Coronary Arteriosclerosis</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>This patient had been treated by Dr. Henry Saage, who has been ill for several months.</b>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>Ne</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <b>1957</b> to <b>4 May 1965</b> , that (1) (we) last saw the deceased alive on <b>Jan 19 1964</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Thomas J. Brennan</b>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5 May 1965</b>		
23C. PHYSICIAN'S NAME (Type) <b>Thomas J. Brennan</b>					23D. ADDRESS <b>5217 Harford Rd Balto 14 Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto Md. 21214</b>			



FUNERAL DIRECTOR: IMPORTANT

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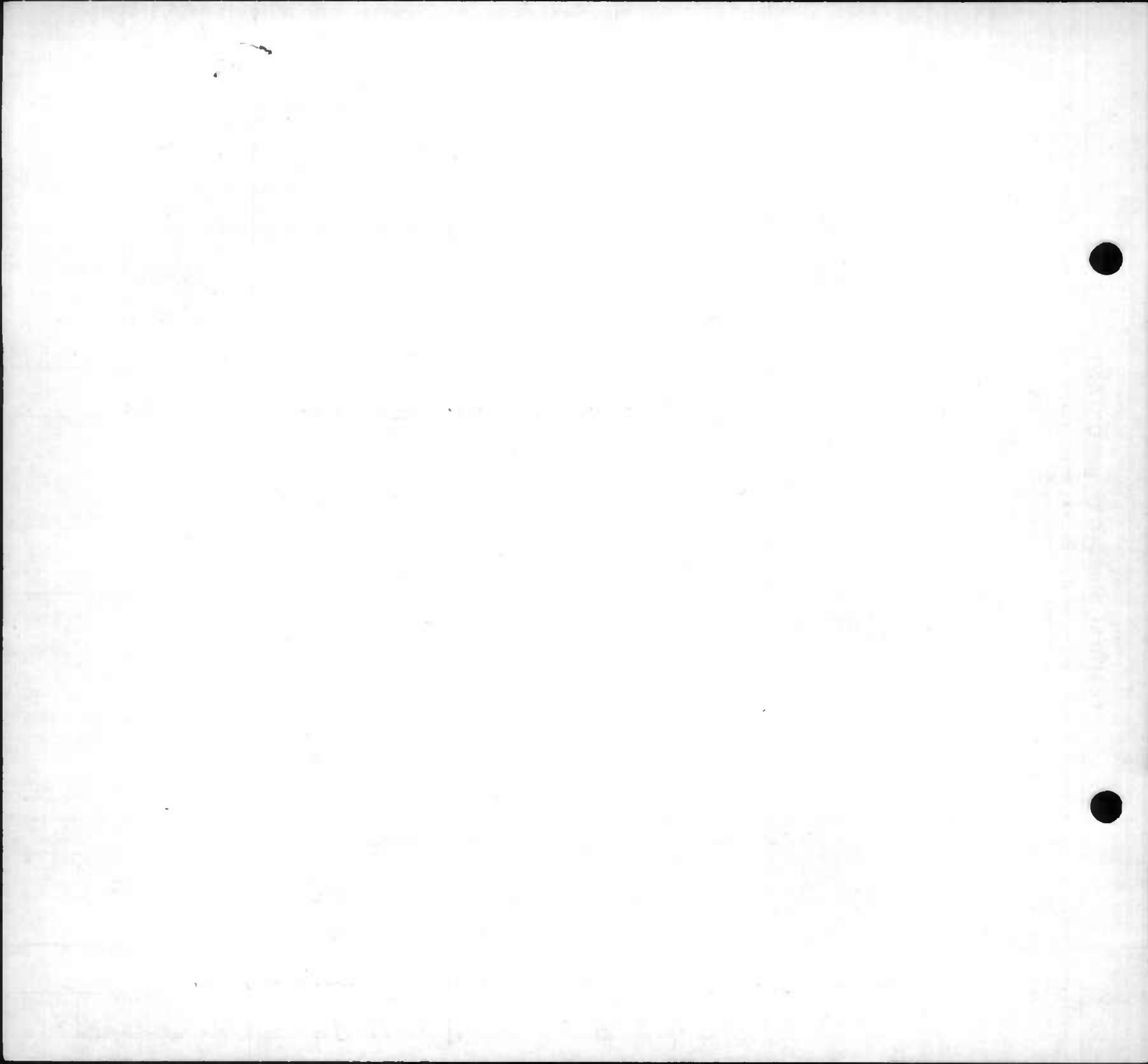
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH										Registered No.	
BIRTH NO.		65 4874									
M.E. CASE NO.		65 4874									
1. NAME OF DECEASED (Type or Print)				Katherine M. Kidd				2. DATE AND HOUR OF DEATH 5/5/65 5:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.				D. STREET ADDRESS (If rural, give location) 6304 MacLean Blvd. McLean			
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Wid.		8. DATE OF BIRTH 12-11-1887		9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Kampe				14. MOTHER'S MAIDEN NAME Katherine Bruck				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
				16. SOCIAL SECURITY NO. —				17. INFORMANT Mrs. Katherine Ryan - Same			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I				CAUSE OF DEATH (A) Intra-Cerebral Hemorrhage (B) Cerebral Arteriosclerosis (C) Arteriosclerotic C-V Dis.				INTERVAL BETWEEN ONSET AND DEATH 18 Hrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (my) (this hospital) attended the deceased from 5/5 5/4 1965 to 5/5 1965, that (my) (we) last saw the deceased alive on 5/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE [Signature]				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 5/5/65			
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS Mercy Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/8/65		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) BALTO., Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS BALTO., Md.					



FUNERAL DIRECTOR: IMPORTANT

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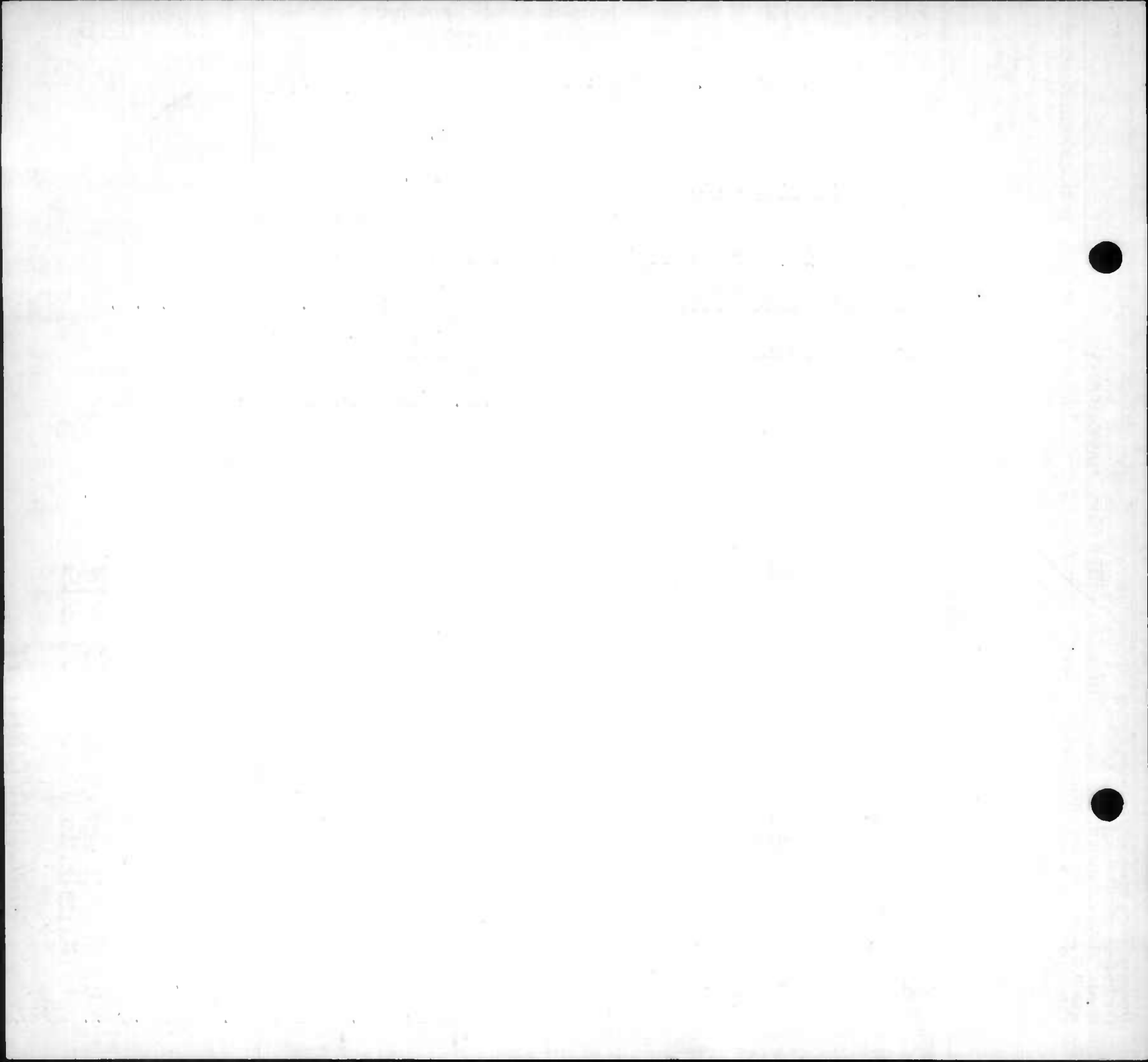
BALTIMORE CITY HEALTH DEPARTMENT				65 4875	
CERTIFICATE OF DEATH				Registered No.	
BIRTH NO. M.E. CASE NO.		65 4875		2. DATE AND HOUR OF DEATH 6 MAY 1965 8:15 A.M.	
1. NAME OF DECEASED (Type or Print) CHESTER D. WANN		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 27-38			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1123 RANSHAWOOD ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/26/00	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSP. SERVICE TLR.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS WANN			
14. MOTHER'S MAIDEN NAME CATHERINE BENNETT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			
16. SOCIAL SECURITY NO. 213019764		17. INFORMANT Mrs. Mabel Wann			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH (A) BRONCHOPNEUMONIA DUE TO 2 METASTASES TO SPINE. (B) DUE TO (C)			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2 MAY 1965 to 6 MAY 1965, that (I) (we) last saw the deceased alive on 6 MAY 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donald M. Barwick				23B. DATE SIGNED 6 MAY 1965	
23C. PHYSICIAN'S NAME (Type) M.D. MARYLAND GENERAL HOSPITAL				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			
25B. NAME OF REGISTRAR R. E. Felt		25C. FUNERAL DIRECTOR L. B. Rusk - BALTO. Md			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 4876					CERTIFICATE OF DEATH					Registered No. 65 4876				
1. NAME OF DECEASED (Type or Print) <b>Paul K. Wingard</b>										2. DATE AND HOUR OF DEATH <b>May 5, 1965</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>2907 Kildaire Drive</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-44</b>				
5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>										8. DATE OF BIRTH <b>1/12/1895</b> 9. AGE (In years last birthday) <b>70</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postal Clerk</b>										11. BIRTHPLACE (State or foreign country) <b>Altoona, Pa.</b>				
13. FATHER'S NAME <b>Charles Wingard</b>										14. MOTHER'S MAIDEN NAME <b>Matilda Ramey</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Mrs. Beatrice Wingard</b>										ADDRESS <b>Same</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Prostate</b>										INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No) <b>no</b>										20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)										21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)														
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)										21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?														
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1, 1964</b> to <b>May 5, 1965</b> , that (I) <del>was</del> last saw the deceased alive on <b>May 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(the)</del> (did not) view the body after death.														
23A. SIGNATURE <b>George Sawyer, Jr.</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>										23B. DATE SIGNED <b>5/7/65</b>				
23C. PHYSICIAN'S NAME (Type) <b>GEORGE SAWYER, JR.</b> M.D.										23D. ADDRESS <b>4808 Harford Rd. Balto 14 Md.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>										24B. DATE <b>5-8-65</b>				
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>										24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>										25B. NAME OF REGISTRAR <b>E. Taylor</b>				
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., Balto., Md.</b>										ADDRESS <b>21214</b>				





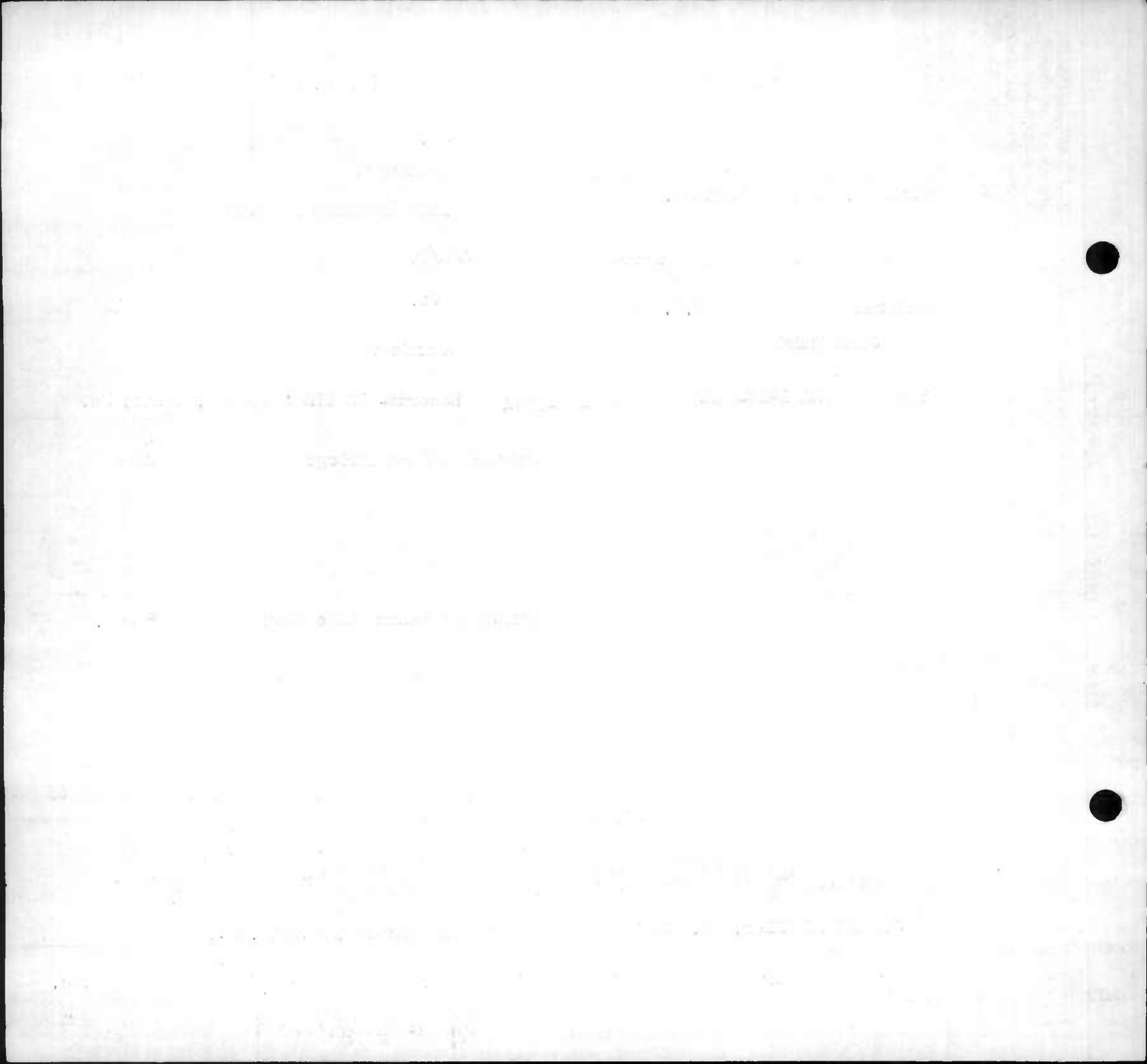
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No.	
65 4877						65 4877	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JONES, Mollie</b>				5-4-65 4:10 PM 4:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>George Washington Carver Nursing Home.</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>10-02</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1023 E. MADISON ST.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>		8. DATE OF BIRTH <b>9/10/1883</b>	9. AGE (In years last birthday) <b>81</b>	11. Under 1 Yr. Months: Days: Hours: Min.	12. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Samuel College</b>		11. BIRTHPLACE (State or foreign country) <b>Calvert Co. Maryland</b>	
13. FATHER'S NAME <b>Richard Jones</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>220-303728 #80</b>		17. INFORMANT <b>George Washington Carver</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diaper Excessive C.V. Disease</b> <b>Direct Decubitus Ulcers</b> <b>See Anemia</b>				ADDRESS <b>607 Pennsylvania Avenue</b> INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1963</b> to <b>May 4th 1965</b> , that (I) (we) last saw the deceased alive on <b>May 3rd 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>M. L. Weaver</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5-4-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. L. Weaver</b>				23D. ADDRESS <b>1944 Druid Hill Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/7/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>mt Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Healst E. Rutter</b>		ADDRESS <b>3035 W. North Ave.</b>	

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SAB-43-40-48

65 4873

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4872

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Joseph Betlejewski - Bailey

2. DATE AND HOUR OF DEATH

5-4-1965

10.15A M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

314 Gussyran Street, 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

3-18-1880

9. AGE (In years  
lost birthday)

85

If Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Painter

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander Betlejewski

14. MOTHER'S MAIDEN NAME

Sophia Justine ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

217-07-9861

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue, 21224

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

## CAUSE OF DEATH

Cerebral Vascular Accident

2-3 days

(A) DUE TO

Meningitis

6 days

(B) DUE TO

(C) Pneumonia

11 days

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Possible Tuberculosis

?

## MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4-22-19 65 to 5-4-19 65  
that (I) (we) last saw the deceased alive on 5-4-19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

5-4-1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-7-65

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus Cemetery

24D. LOCATION

(City, town, or county)

(State)

6515 Boston Street Balto, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 7 1965

25B. NAME OF REGISTRAR

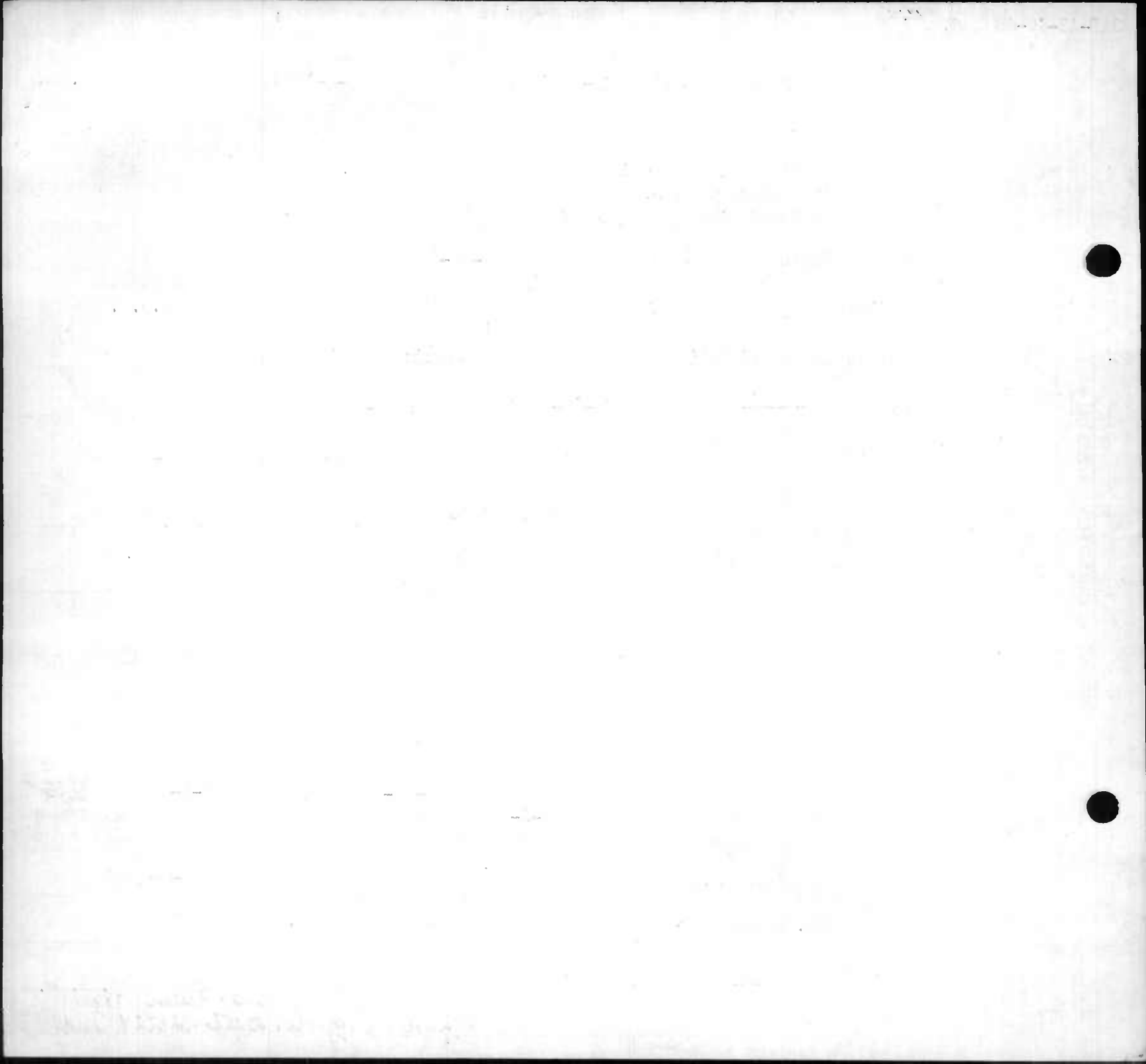
Robert E. Fagundes

25C. FUNERAL DIRECTOR

6224 Eastern Ave  
Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

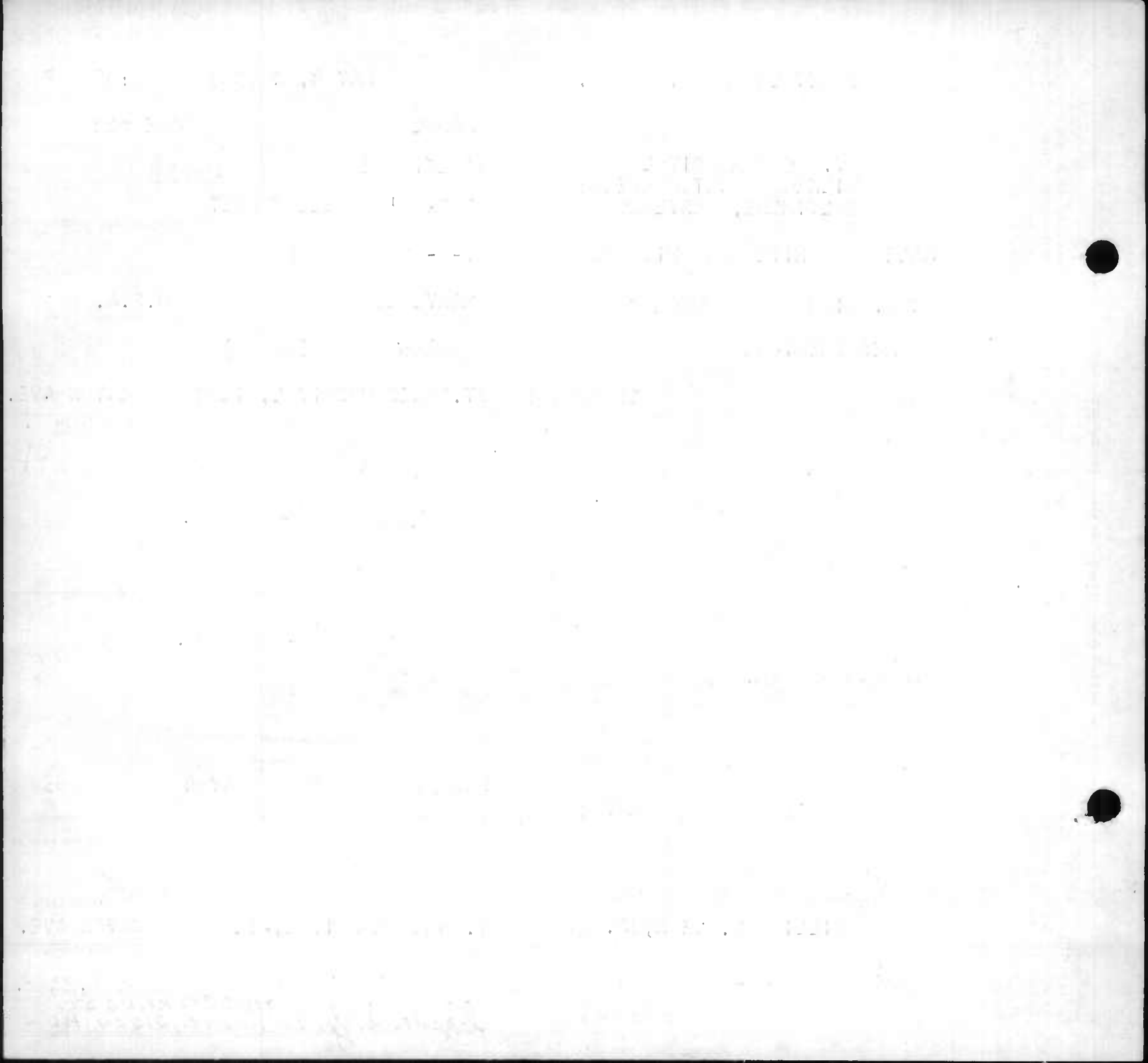
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPT.		65 4880		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>JAMES LEO SHERIDAN Sr.</b>				2. DATE AND HOUR OF DEATH <b>MAY 4, 1965 5:45 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVENUE BALTIMORE, MARYLAND</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ZONE #24</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2924 O'DONNELL STREET</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b>		8. DATE OF BIRTH <b>1-8-02</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. City Worker</i>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JAMES SHERIDAN</b>				14. MOTHER'S MAIDEN NAME <i>Catherine (BROWN)</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216092484</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>					
18. <b>420.1X1260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction recent</b>				CAUSE OF DEATH (A) DUE TO <b>Acute myocardial infarction recent</b>				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease</b>				(B) DUE TO <b>Arteriosclerotic heart disease</b>				(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes mellitus a urinary tract infect</b>									
19A. DATE OF OPERATION <b>4-5-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrene of foot</i>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Room</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 31</b> 19 <b>65</b> to <b>MAY 4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>MAY 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>William A. Dear, Jr.</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM A. DEAR, JR.</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-8-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7401 German Hill Road Balto., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <i>Robert E. Farkner</i>		25C. FUNERAL DIRECTOR <i>Charles S. Giller</i>		ADDRESS <b>901 S. CONKLIN ST. BALTO., 21224, MD.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 4881</b>	
BIRTH NO. <b>65 4881</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>MAY 2-1965 12:20 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>SALLY B. STATES</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 5-18-65</b> HOSPITAL OR INSTITUTION <b>University Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Rock Hall Kent</b>	
5. SEX <b>F</b>		D. STREET ADDRESS (If rural, give location) <b>64-00</b>	
6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>1907 2-28-04</b>	9. AGE (In years last birthday) <b>56 58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>DELAWARE</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gove Morris</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Walls</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-42-0185</b>	
		17. INFORMANT ADDRESS <b>HOSPITAL RECORDS</b>	
18. <b>199-2-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypercalcemia due to Metastatic Carcinoma - probably - Primary Site - unknown</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-26-65</b> to <b>5-2-65</b> , that (I) (we) last saw the deceased alive on <b>5-2-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Francine Camitta</b>		23B. DATE SIGNED <b>5/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Francine Camitta M.D.</b>		23D. ADDRESS <b>UNIVERSITY HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>MAY 5 1965</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Chester Conn. Chester Conn. Md.</b>		24D. LOCATION (City, town, or county) (State) <b>CHURCH HILL, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>EDGARD KANE</b>		ADDRESS <b>CHURCH HILL, MD.</b>	

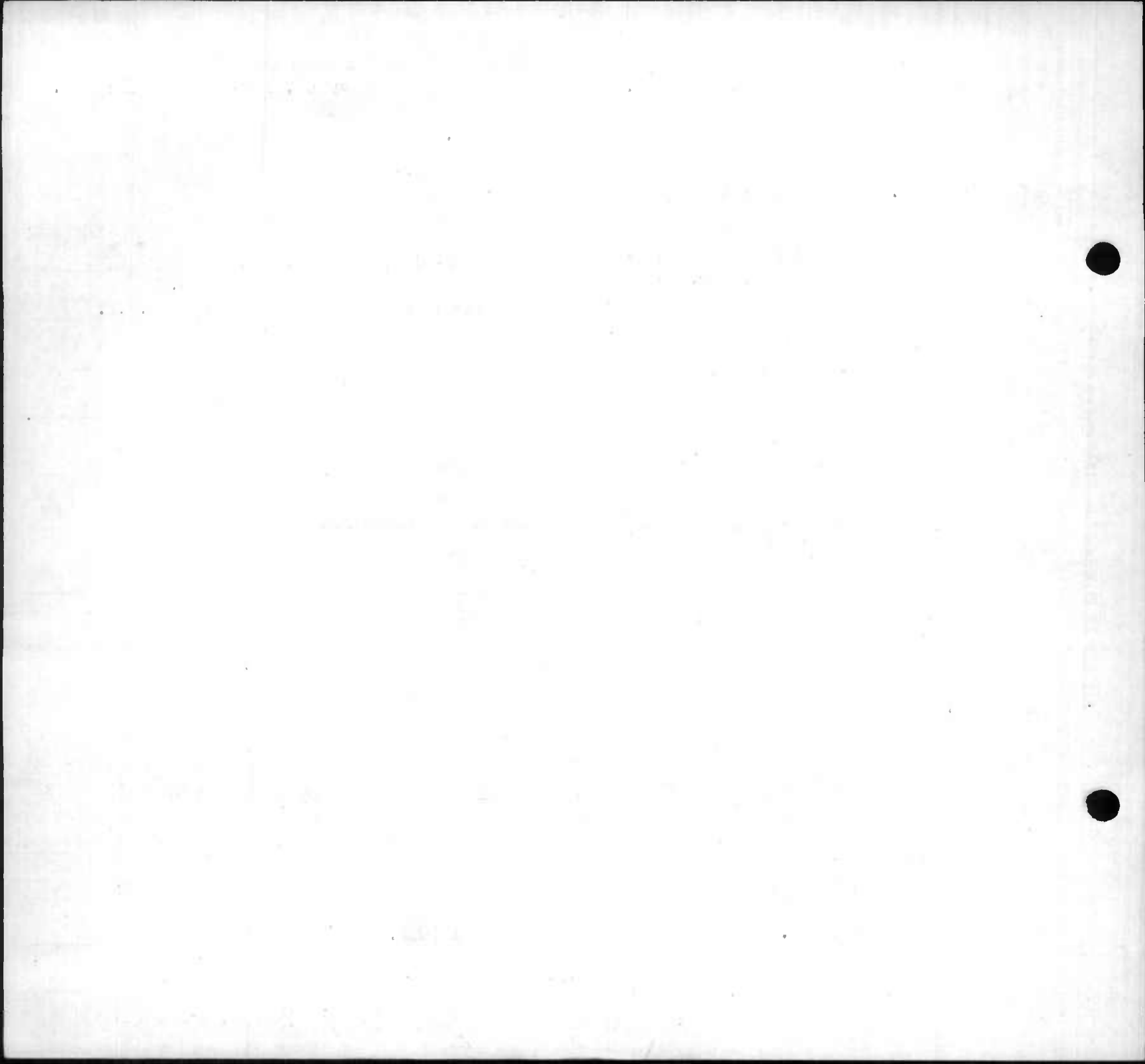
V.S. 153

5-18-65

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4882</u>	
BIRTH NO. <u>65 4882</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>May 6, 1965</u> <u>11:55 P.</u> M.			
1. NAME OF DECEASED (Type or Print) <u>WILLIAMS, GEORGE L.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>8-03</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Joseph Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>13</u> D. STREET ADDRESS (If rural, give location) <u>2733 Preston Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>12/13/00</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tigger</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>George Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-09-9988</u>		17. INFORMANT <u>Grace B. Williams</u> ADDRESS <u>2733E Preston</u>	
18. <u>600.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Uremia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Pyelonephritis</u>		CAUSE OF DEATH (A) <u>Uremia</u> DUE TO (B) <u>Chronic Pyelonephritis</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19 <u>65</u> to <u>5/6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>5/6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel A. Gongon</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>5/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Manuel A. Gongon</u>		23D. ADDRESS M.D. <u>1400 N. Caroline Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>	
24D. LOCATION <u>Arbutus Md.</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fairman</u>		25C. FUNERAL DIRECTOR <u>Robert T. Ellickson</u> ADDRESS _____	

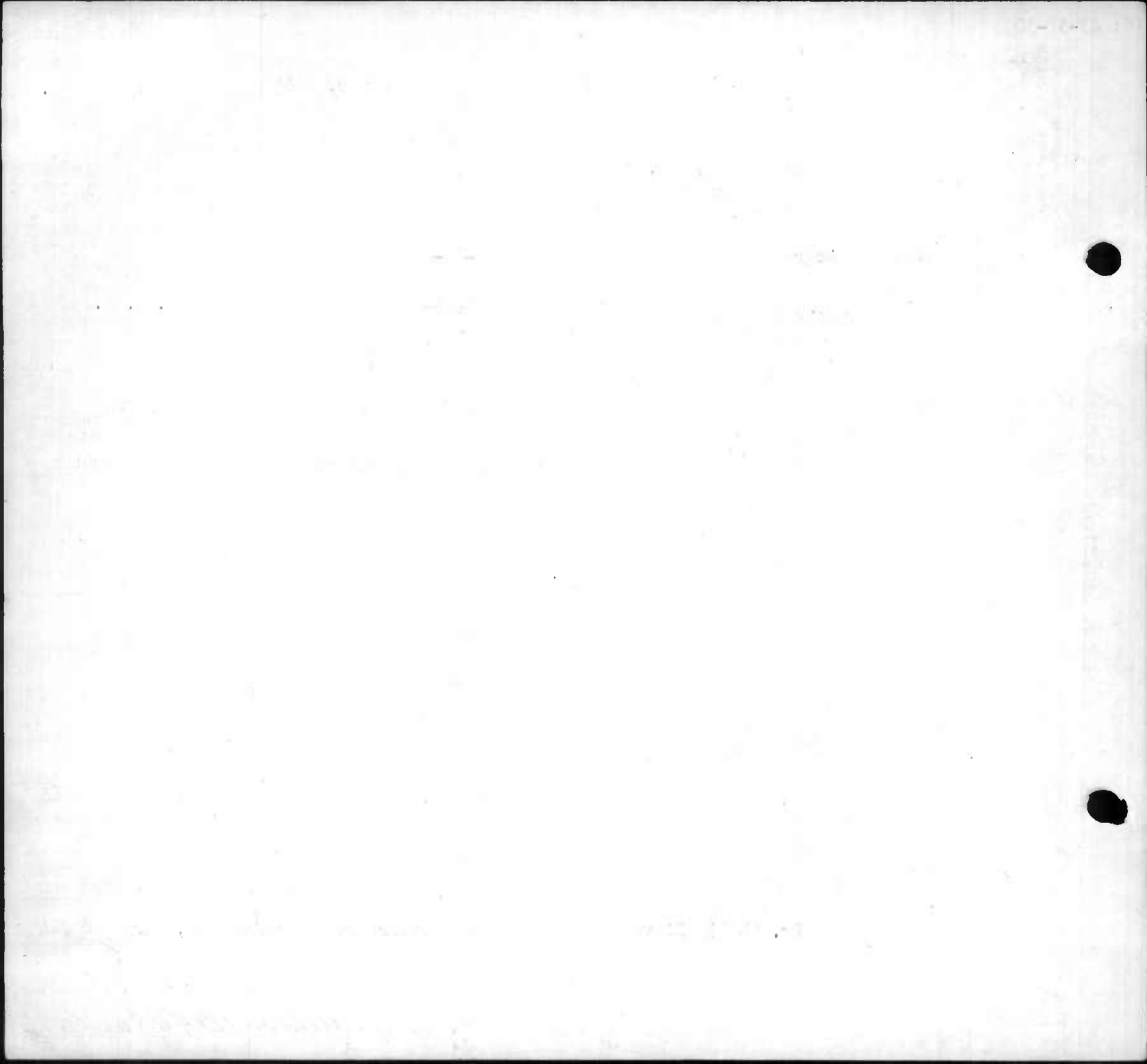


LS: 43-51-30 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)		Sylvester Queen		2. DATE AND HOUR OF DEATH May 5, 1965 6:30 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				Maryland 25-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3317 Fairfield Road #21226	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 1-18-25	9. AGE (In years last birthday) 40	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #24	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 3 Minutes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia Hepatitis				2 Weeks	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 4, 1965 to May 5, 1965, that (I) (we) last saw the deceased alive on May 5, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Zieve				23B. DATE SIGNED May 5, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Philip Zieve				23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland #24	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 8/65		24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem.	
24D. LOCATION (City, town, or county) (State) A.A. County Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR Zieve & E. E. E. 11297 Carroll St			



65 4884

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4884

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>SOPHRINA WRIGHT</b>				2. DATE AND HOUR PRONOUNCED DEAD May 5, 1965 4:25 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>St. Joseph Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>9-09</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1408 E. Oliver St.</b>			
5. SEX <b>female</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>Jan 9, 1927</b>	9. AGE (In years last birthday) <b>38</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ind</b>		11. BIRTHPLACE (State or foreign country) <b>ind</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Edna ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>George Wright 1408 E. Oliver St</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO <b>Generalized purulent peritonitis</b>		INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO <b>Ruptured duodenal ulcer</b>			
				(C) DUE TO			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> DATE SIGNED <b>5-5-65</b> EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>May 8/65</b>		23C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cem.</b>		23D. LOCATION (City, town, or county) (State) <b>Westport Md</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 7 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. Jank...</b>		24C. FUNERAL DIRECTOR ADDRESS <b>Frank T. Eichen 1129 N. Calver</b>			

VALLEY ENGINEERING

PAID OFFICE

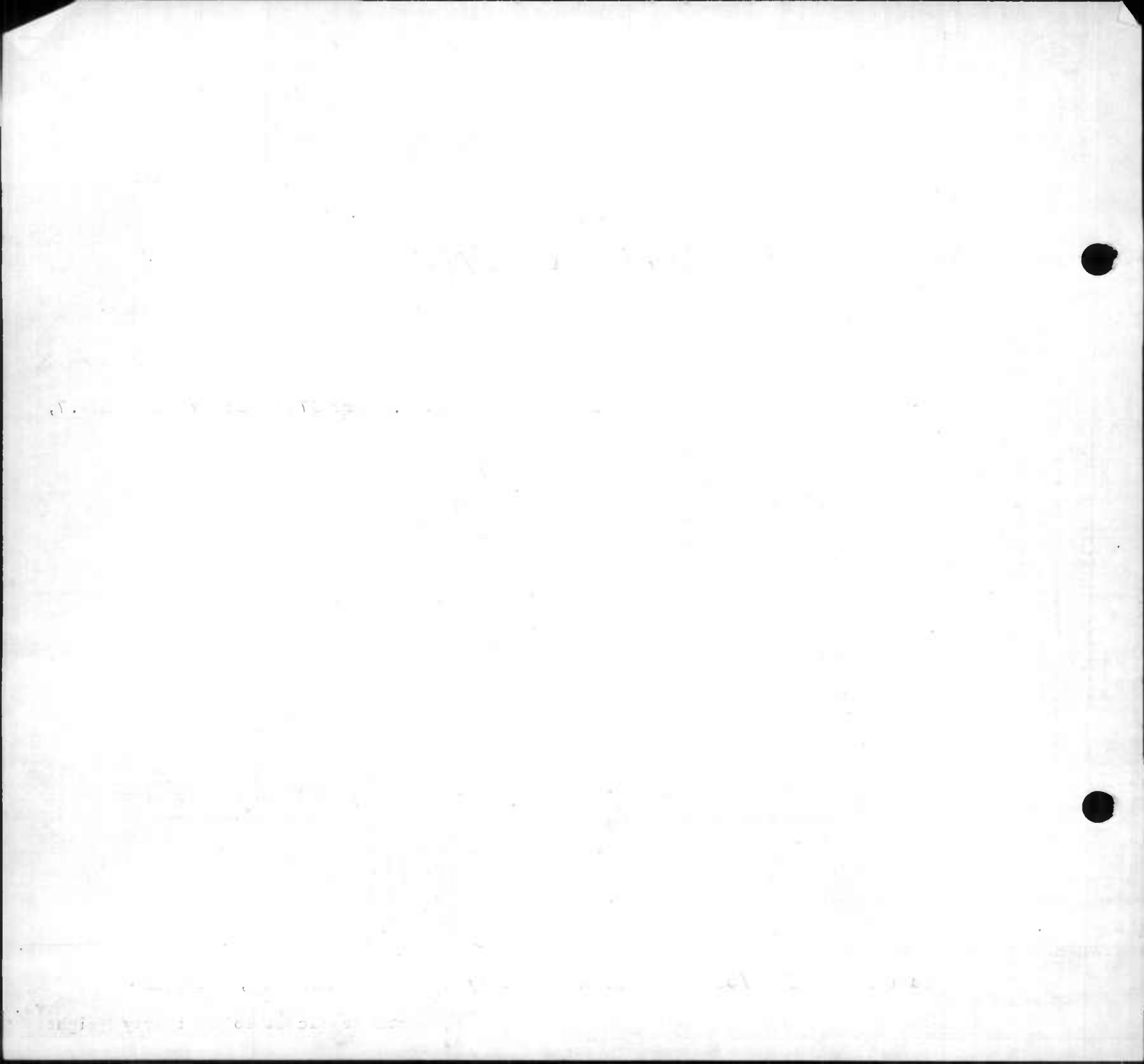
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

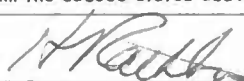
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 4885</u>	
BIRTH NO. <u>65-10365</u> <u>65 4885</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>DAVID JOSEPH TORR</u>				2. DATE AND HOUR OF DEATH <u>MAY 8, 1965</u> <u>7:05</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MD. GEN. Hosp.</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MD.</u>		B. COUNTY <u>BALTO</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO</u> <u>#7</u> <u>3300</u>			
				D. STREET ADDRESS (If rural, give location) <u>3724 OAK AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u>		8. DATE OF BIRTH <u>April 30, 1965</u>	9. AGE (In years last birthday) <u>8</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT LIVINGSTON TORR</u>				14. MOTHER'S MAIDEN NAME <u>EVELYN MULLINEAUX</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Robert L. Torr 3724 Oak Avenue Balto. 7,</u>			
18. <u>754.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Complete Transposition of Aorta and Pulmonary artery</u>				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> 19 <u>65</u> to <u>5-8</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>7-5-8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>T. M. LAU</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-8-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>T. M. LAU</u>				23D. ADDRESS <u>2nd. General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farkas</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Heights Ave.</u>	

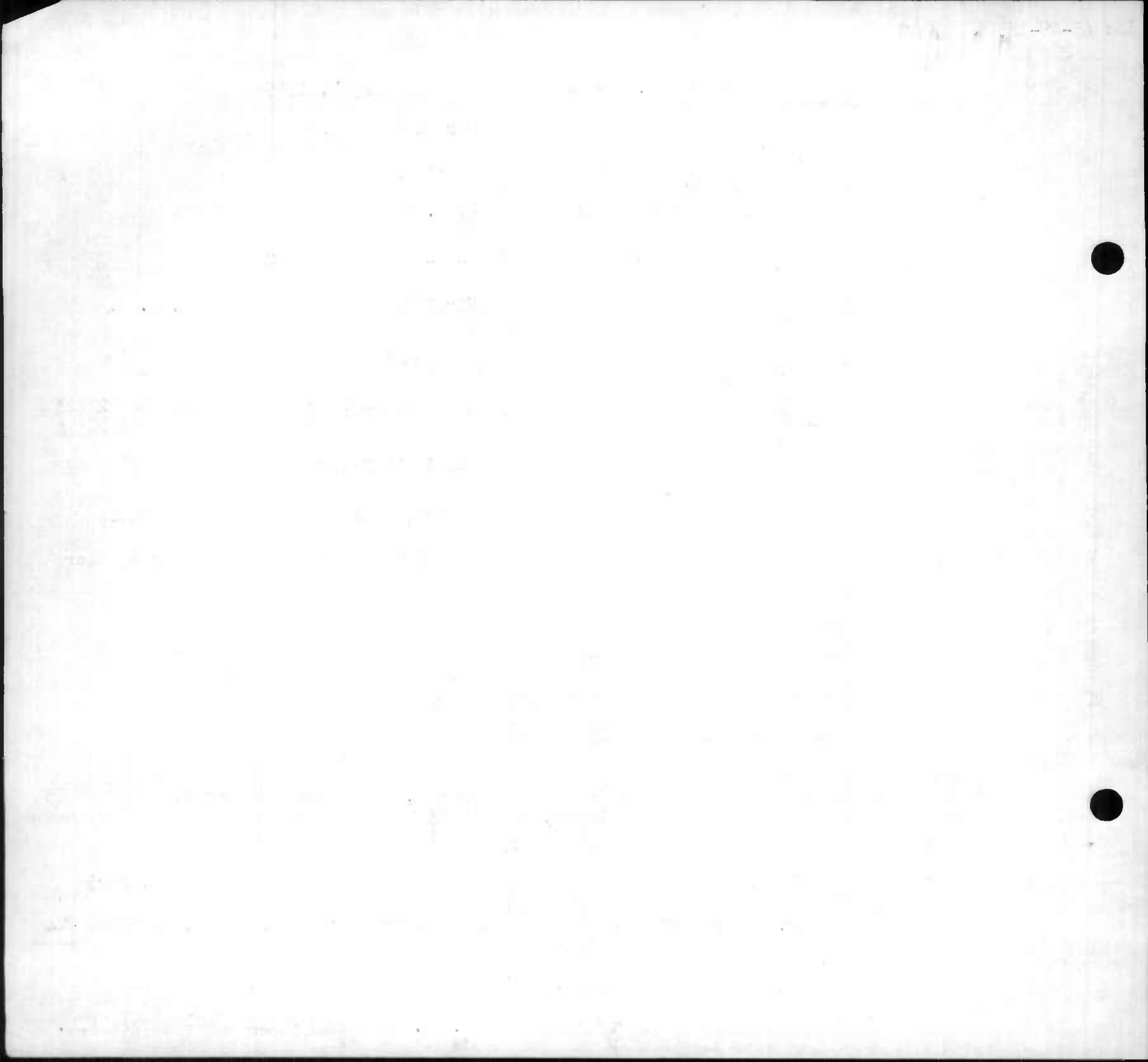


FUNERAL DIRECTOR: IMPORTANT

LS: 43-49-18

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <b>65 4886</b>	
BIRTH NO. <b>65 4886</b>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Robert E. Hughes</b>		2. DATE AND HOUR OF DEATH <b>May 8, 1965 6:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-44</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hosptials 4940 Eastern Avenue Baltimore, Maryland #21224</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>27 N. Highland Avenue #21224</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>9-11-1914</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Paving</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>225 10 1097</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthemia, etc. It means the disease, injury or complication which caused death.) <b>450.0 I</b> <b>Respiratory Arrest</b>				CAUSE OF DEATH (A) DUE TO <b>Respiratory Arrest</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>Stroke, Aspiration, Pneumonia</b>				(B) DUE TO <b>Stroke, Aspiration, Pneumonia</b>		<b>Hours</b>	
				(C) DUE TO <b>Arteriosclerotic Vascular Disease</b>		<b>Years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 2,</b> 19 <b>65</b> to <b>May 8,</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>May 8,</b> 19 <b>65</b> and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>May 8, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Howard Rathbun</b>				23D. ADDRESS M.D. <b>4940 Eastern Avenue Baltimore, Maryland #24</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore, National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farkner</b>		25C. FUNERAL DIRECTOR <b>Johnson 8521 Loch Raven Bl.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4887				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4887	
M.E. CASE NO.				1. NAME OF DECEASED			
(Type or Print)				Willie Hazelwood			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
Provident Hospital 1514 Division Street Baltimore, Maryland				A. STATE Maryland B. COUNTY 15-04			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
Baltimore				2724 Pennsylvania Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
Male	Negro	Widowed	12-9-06	59			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer		Construction		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Robert Hazelwood				Emma			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Ernest Rainey		2724 Penna. Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				Cardio-respiratory failure			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				Cancer of B. part of metabolism			
				(C) Severe anemia			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 5, 1965 to May 7, 1965, that (I) (we) lost saw the deceased alive on May 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Delfin David						May 8, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				1514 Division Street			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/10/65		Mt. Calvary Cemetery		AnnArundel Cty Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 10 1965		Robert E. Taylor		A. Halstead		1206 W. North Ave	

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I have received  
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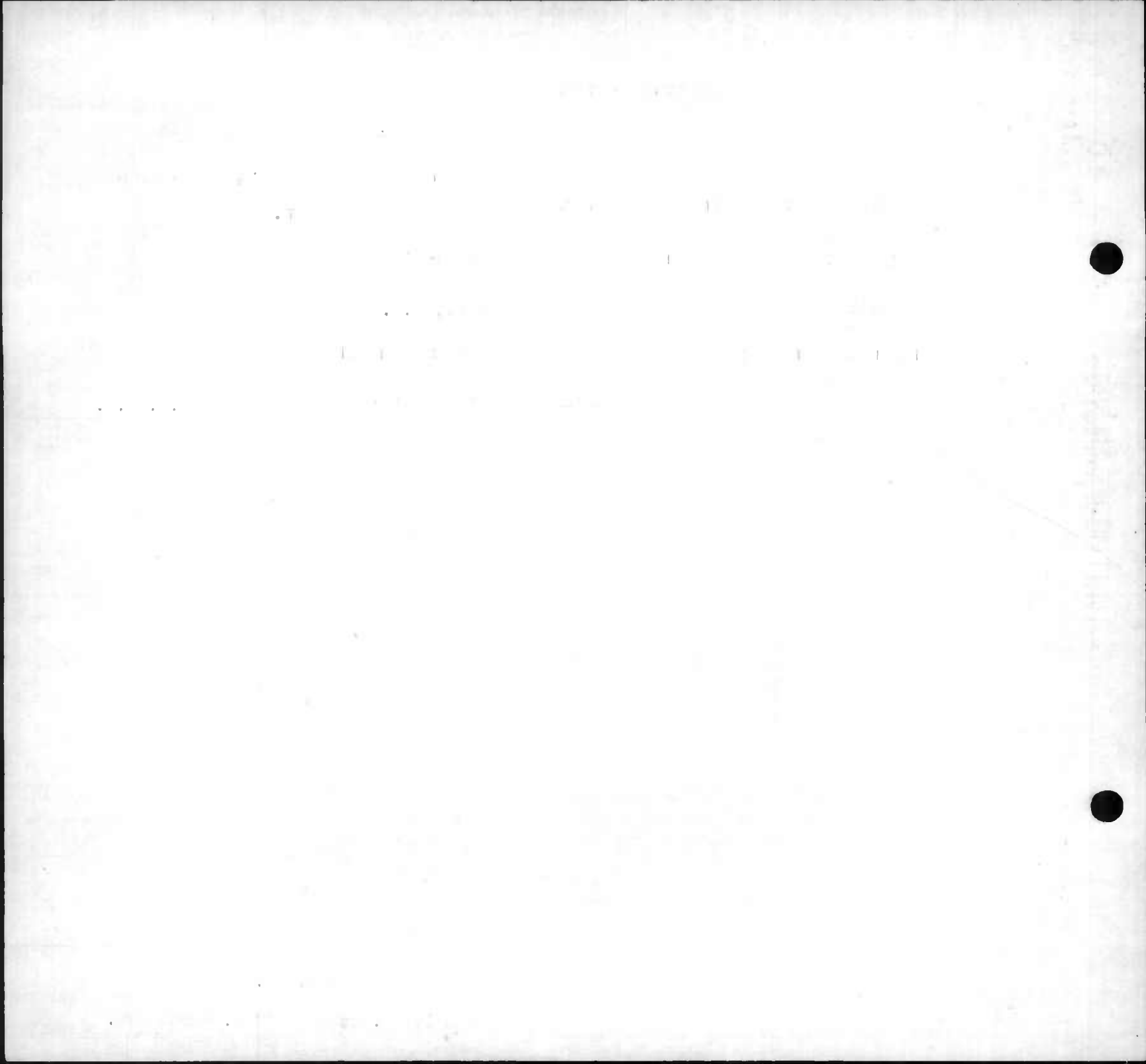
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4888		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4888	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print)		
JEANNETTE GATEN			2. DATE AND HOUR OF DEATH 5-5-65 1 530 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
THE JOHNS HOPKINS HOSPITAL			NEW YORK		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			SPRINGFIELD GARDEN, LONG ISLAND		
			D. STREET ADDRESS (If rural, give location)		
			125-07 LUCAS ST.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FEMALE	NEGRO	WIDOWED	1-20-08	57	Domestic
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Wash., D.C.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WILLIAM BRISCOE			EFFIE WILLIAMS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			217-20-9672		Viola White 125-07 Lucas St L.I. N.Y.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5-4 19 65 to 5-5 19 65, that (I) (we) last saw the deceased alive on 5-5 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
BRUCE LEE EVATT M.D.			JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5/10/65	New Cathedral Cemetery		Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1965		Robert E. Farley M.D.		William C. March 928 E. North Ave.	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No.	
BIRTH NO.		65 4889				65 4889	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Williams, James Oliver				8-May 65 10 <sup>00</sup> A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  University Hosp				A. STATE Md			
				B. COUNTY Belt			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 1126 Myrtle Ave			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) wid	8. DATE OF BIRTH 9/29/75		9. AGE (In years - last birthday) 82	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Williams				14. MOTHER'S MAIDEN NAME Henriette Taylor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-09-2844		17. INFORMANT ADDRESS Benjamin Williams 1126 Myrtle Avenue	
18. 609X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Septicemia DUE TO (B) Perineurethral etc DUE TO (C) Abscesses		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Venous Iliopemoral Thrombosis							
19A. DATE OF OPERATION 03/4		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Emerg		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1 May 1965 to 8 May 1965, that (I) (we) last saw the deceased alive on 8 May 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 8 May 65	
23C. PHYSICIAN'S NAME (Type) Jesse Marcel				23D. ADDRESS M.D. c/o U. H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-65		24C. NAME OF CEMETERY or CREMATORY Simpson Church Cemetery		24D. LOCATION (City, town, or county) (State) Poplar Spring, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Morton & Dyett Fun. Home		ADDRESS 1701 Laurens St.	

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University of Chicago

M. C. W.

Professor

Benjamin Williams

Henrietta

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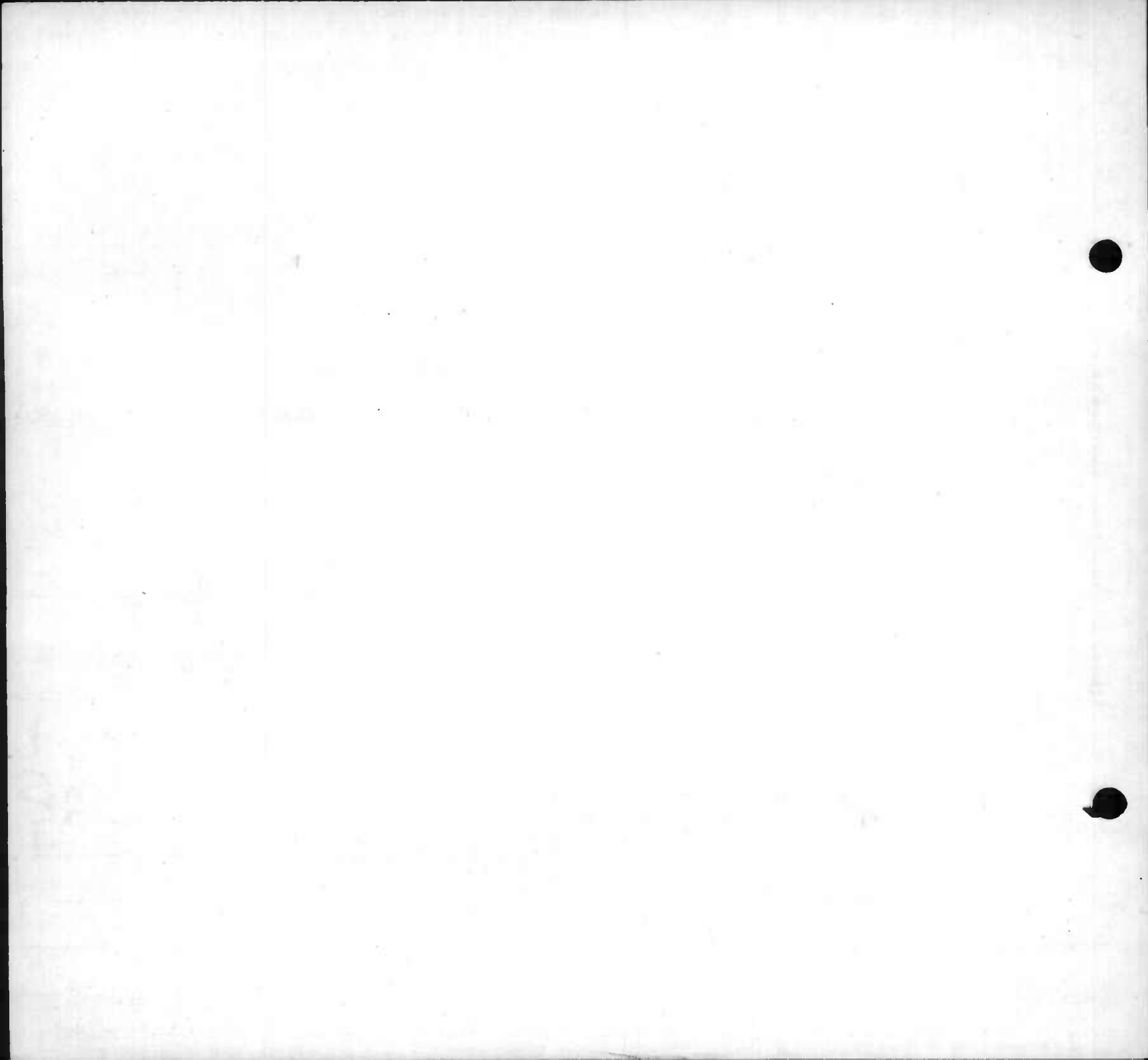
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

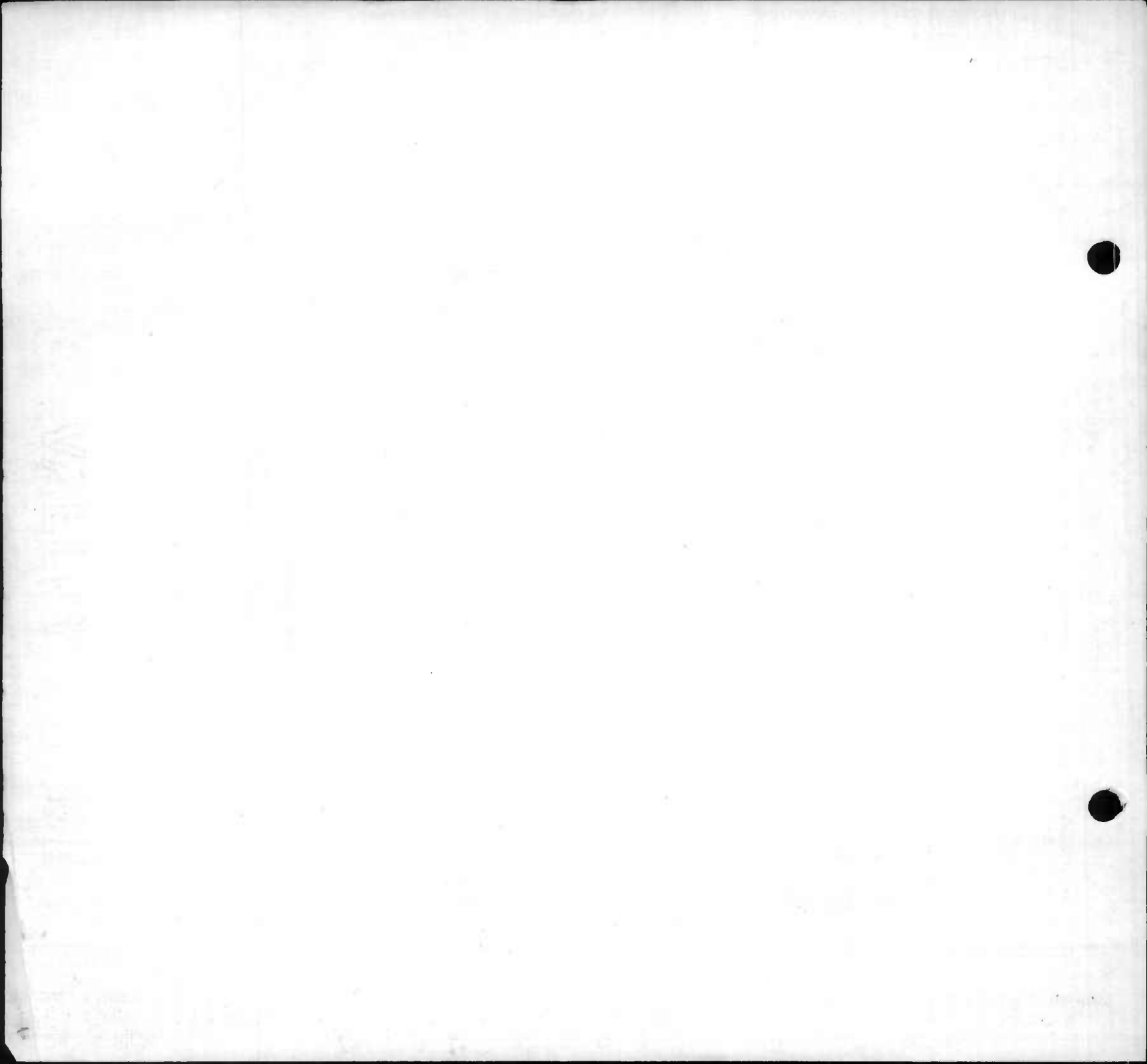
BALTIMORE CITY HEALTH DEPARTMENT									
65 4890					65 4890				
BIRTH NO.					Registered No.				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <b>SIMPKINS ADA.</b>					2. DATE AND HOUR OF DEATH <b>5/7/65 2:30 AM 29° AM.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hosp. of Md.</b>					A. STATE <b>MD</b> B. COUNTY <b>20-07</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>				
					D. STREET ADDRESS (If rural, give location) <b>48 S. Morley St</b>				
5. SEX <b>Female</b>	6. RACE <b>colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>June 8-1973</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Tom Gant</b>			14. MOTHER'S MAIDEN NAME <b>Janie Neil</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No -</b>			16. SOCIAL SECURITY NO. <b>219-01-4431</b>		17. INFORMANT <b>MRS. Elsie Porter</b>				
18. <b>443X1</b>			CAUSE OF DEATH			ADDRESS <b>1908 N. Fulton Ave.</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <b>C.V.A.</b> DUE TO <b>Cerebral Hemorrhage due To Hypertensive. C.V. disease.</b>						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO						
			(C)						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>2</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/5/65</b> 19 to <b>5/7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>2:30 AM 5/7</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>S. Rajae</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/7, 65</b>		
23C. PHYSICIAN'S NAME (Type) <b>SAROOSH RAJAE</b>					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Robert E. Taylor &amp; Dyett Funil. Home Inc</b>					



FUNERAL DIRECTOR: IMPORTANT

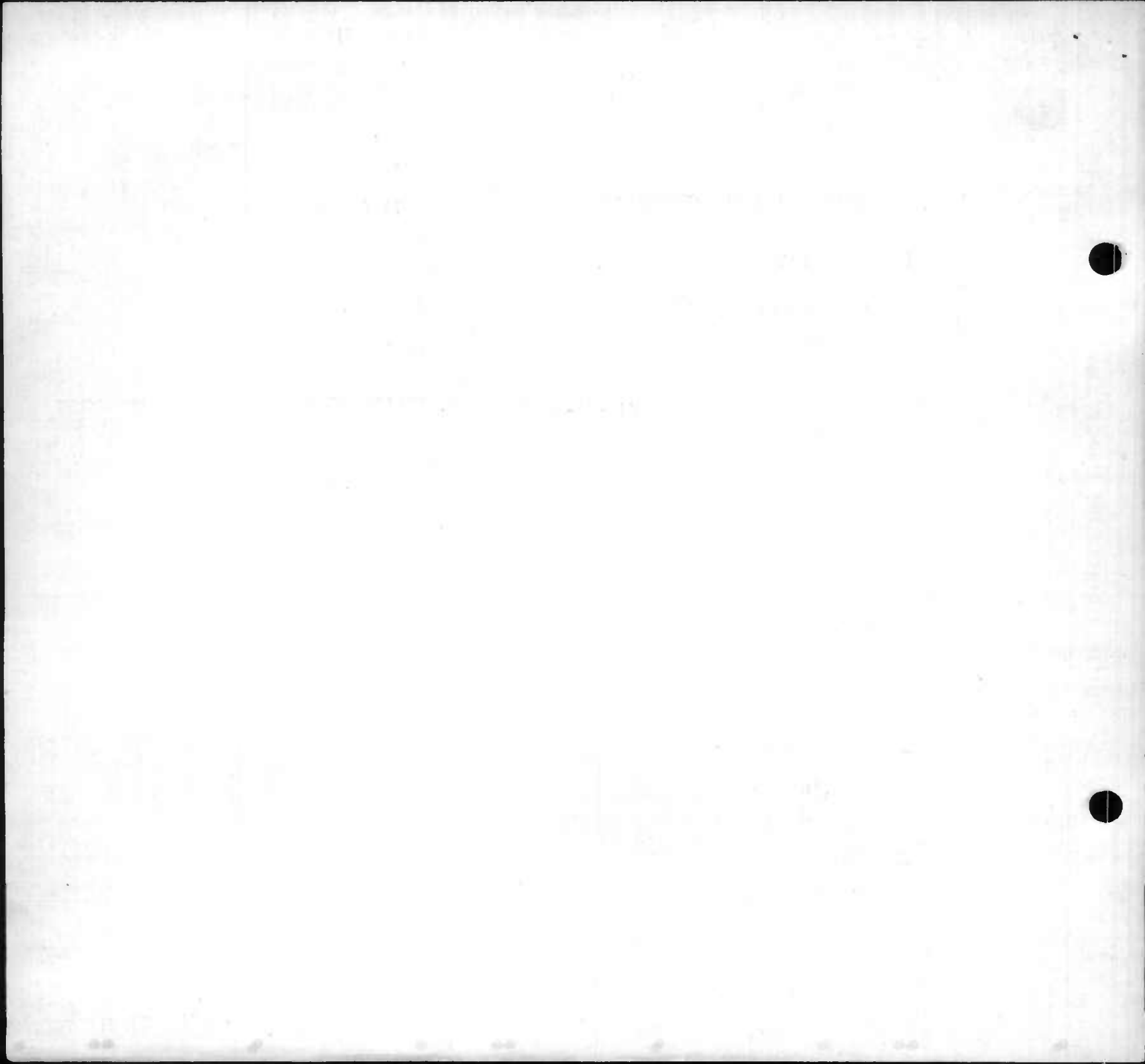
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 4891	
BIRTH NO. 65 4891		<b>CERTIFICATE OF DEATH</b>		REGISTERED NO. 65 4891	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>SAMUEL LEVIN</b>		2. DATE AND HOUR OF DEATH <b>MAY 8, 1965 1 6:12 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE <b>MARYLAND</b> B. COUNTY <b>15-10</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>3912 LIBERTY HEIGHTS AVE</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		D. STREET ADDRESS (If rural, give location) <b>3912 LIBERTY HEIGHTS AVE</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG 16, 1890</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>GROCEER</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MEYER</b>		14. MOTHER'S MAIDEN NAME <b>SHIRLEY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-367124</b>		17. INFORMANT <b>WIFE</b> ADDRESS <b>SAME</b>	
18. <b>15-1X I</b>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) <b>GENERALIZED CARCINOMATOSIS - 7 MONTHS</b>		(B) <b>CARCINOMA - STOMACH - 2 YEARS</b>	
ANTECEDENT CAUSES		(B) DUE TO		(C) _____	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>MAY 15, 1963</b> to <b>MAY 8, 1965</b> , that (I) <del>(he)</del> last saw the deceased alive on <b>MAY 8, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Norman R. Kleinman</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>5/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>NORMAN R. KLEINMAN</b>		23D. ADDRESS <b>3803 EDMONDSON AVE - BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/9/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ROSEDALE</b>	
24D. LOCATION (City, town, or county) <b>BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, INC</b>		ADDRESS <b>3319 Olympia Ave</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

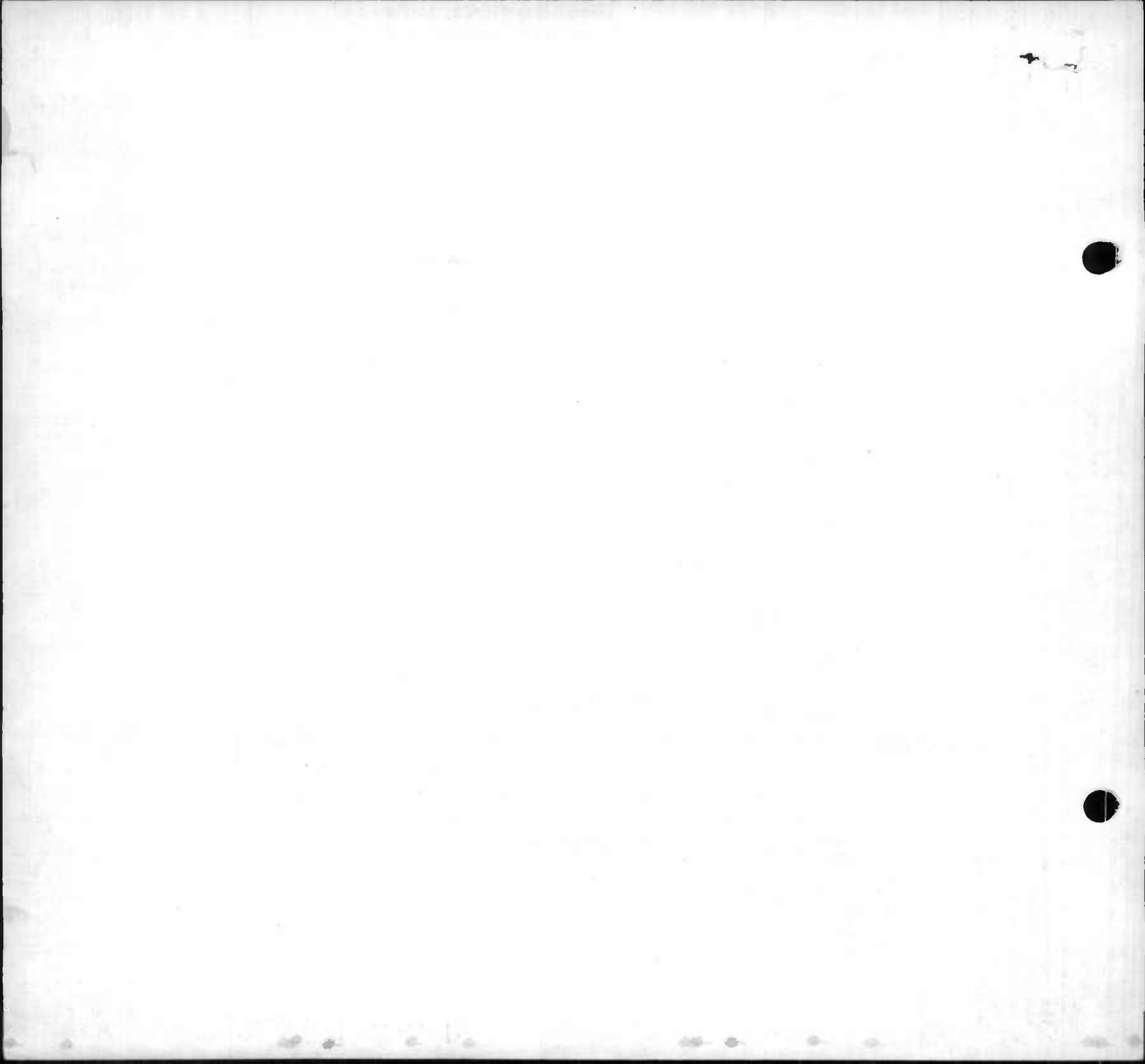
BALTIMORE CITY HEALTH DEPARTMENT									
65 4892					Registered No. 65 4892				
BIRTH NO.					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <u>Alvin Robert Stern</u>					2. DATE AND HOUR OF DEATH <u>May 5, 1965</u> <u>8:10 P.M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>SOUTH BALTIMORE GENERAL HOSPITAL</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>8019 WOODGATE COURT APT B</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>59</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MANAGER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>ICM PROGRAMING</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEON STERN</u>					14. MOTHER'S MAIDEN NAME <u>BERTHA ROSE</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>212-03-4492</u>		17. INFORMANT <u>MRS. TILLIE STERN</u>				ADDRESS <u>8019 WOODGATE COURT</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>420.1H260X</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u>					CAUSE OF DEATH (A) <u>Ventricular fibrillation</u> DUE TO <u>secondary to myocardial infarction</u> (B) <u>Arterio sclerosis</u> DUE TO <u>unknown</u> (C) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> <u>1963</u> to <u>May 5</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>David I. Miller</u> M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>May 5, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>David I. Miller</u> M.D.					23D. ADDRESS <u>Liason Rd. Owings Mills, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/7/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>BETH EL MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fink</u>			25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

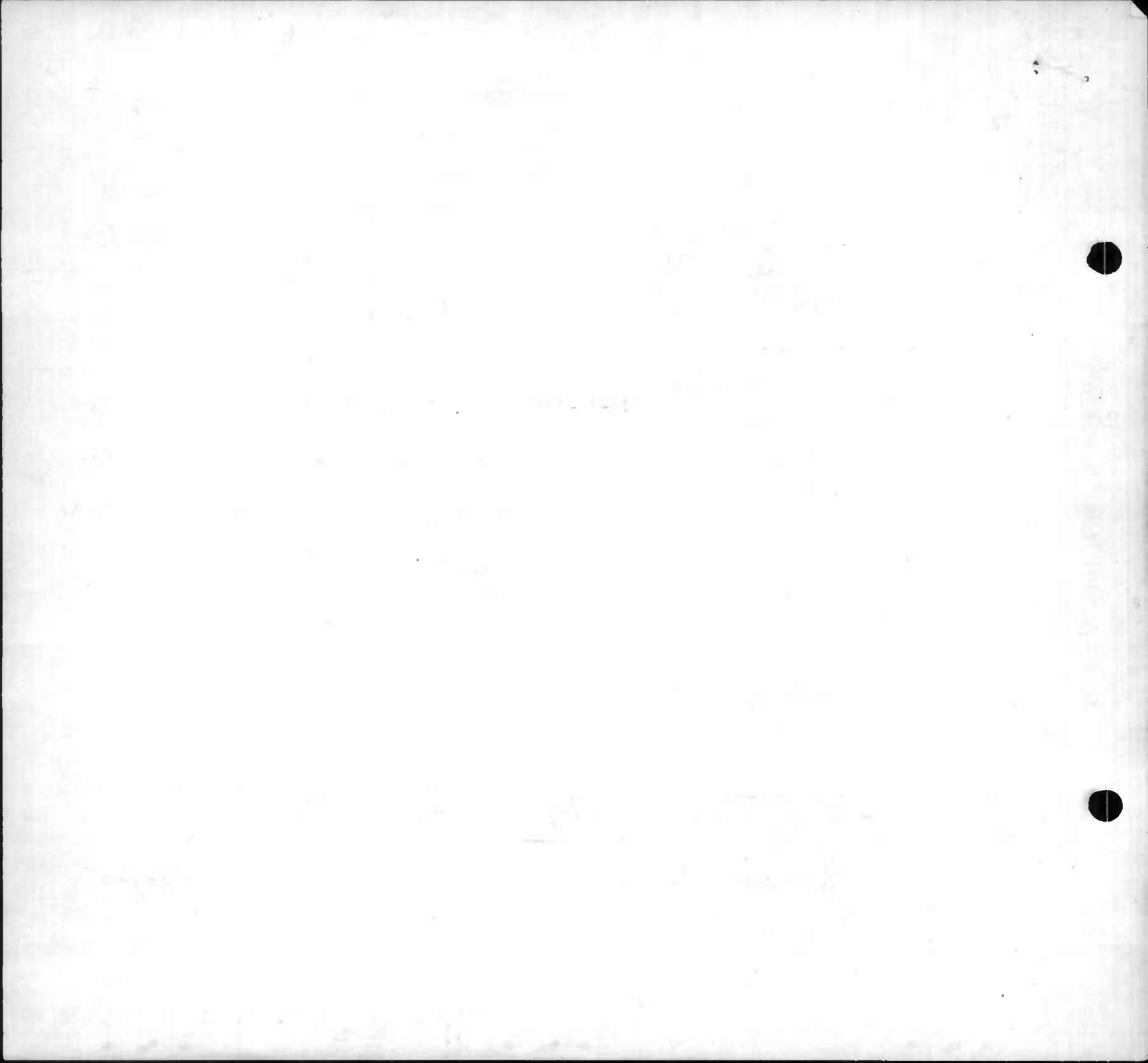
VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

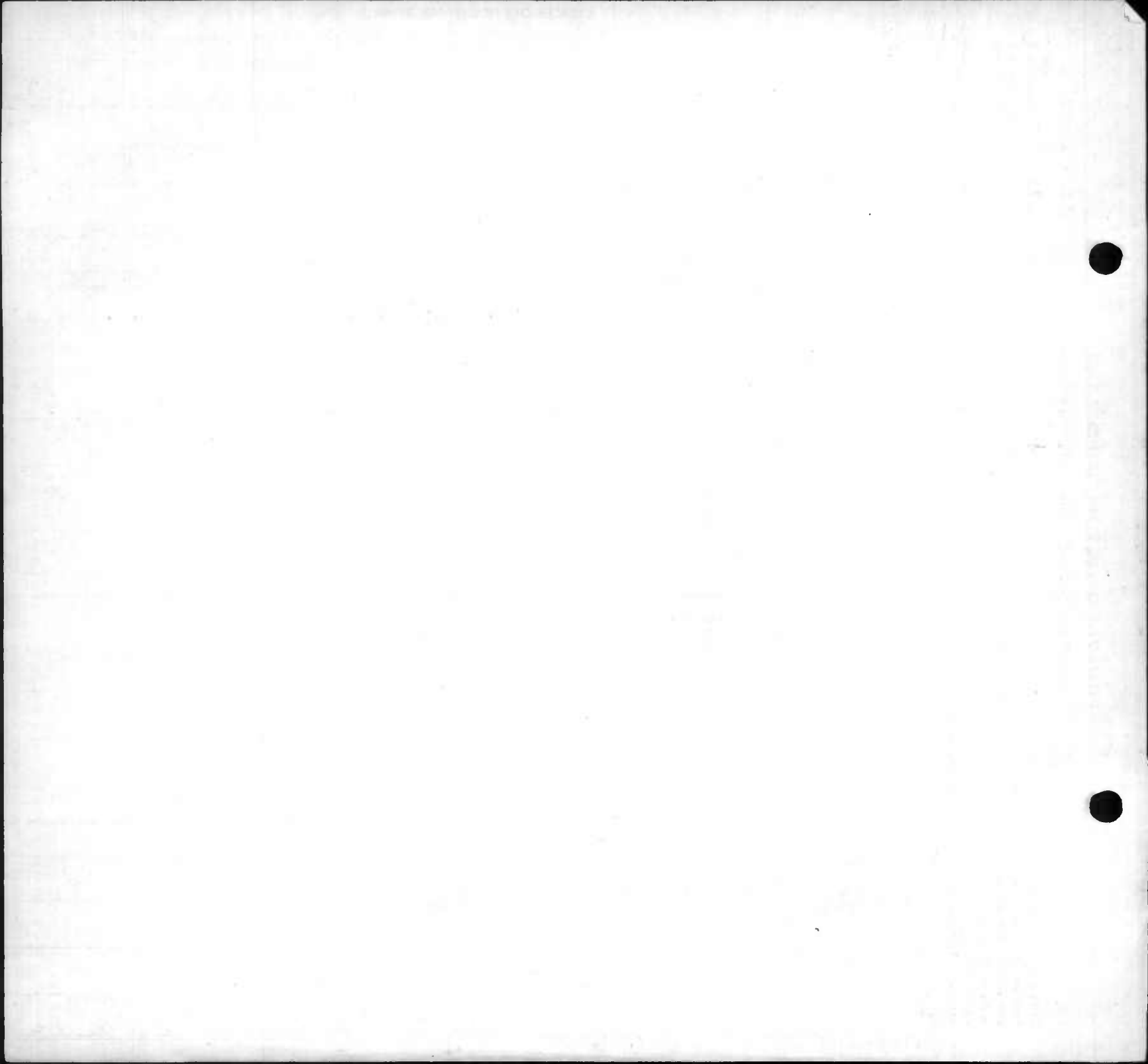
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4894</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4894</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Carrie Sussman</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">May 5, 1965</span> <span style="font-size: 1.2em;">6:30 P. M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">27-16</span>			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">Belvedere Nursing Home</span> <span style="font-size: 1.2em;">W. Belvedere Avenue</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4603 REISTERSTOWN ROAD</span>	
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">NEVER MARRIED</span>	8. DATE OF BIRTH	9. AGE (In years last birthday) <span style="font-size: 1.2em;">83</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SECRETARY</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">TRANSIT</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">HENRY SUSSMAN</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ELLEN SAMUELS</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-10-2930</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MR. JOSEPH SUSSMAN 3508 LANGREHR ROAD</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Ante Myocardial Infarction</span>		CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span> (B) DUE TO <span style="font-size: 1.2em;">2 mo</span> (C) <span style="font-size: 1.2em;">none</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 day</span> <span style="font-size: 1.2em;">6 years</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 1</span> 19 <span style="font-size: 1.2em;">59</span> to <span style="font-size: 1.2em;">May 5</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">May 5</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Manuel Levin</span>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5/6/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">MANUEL LEVIN</span>		23D. ADDRESS M.D. <span style="font-size: 1.2em;">4818 REISTERSTOWN ROAD</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5/7/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">HEBREW FRIENDSHIP</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE MARYLAND</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 10 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</span>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

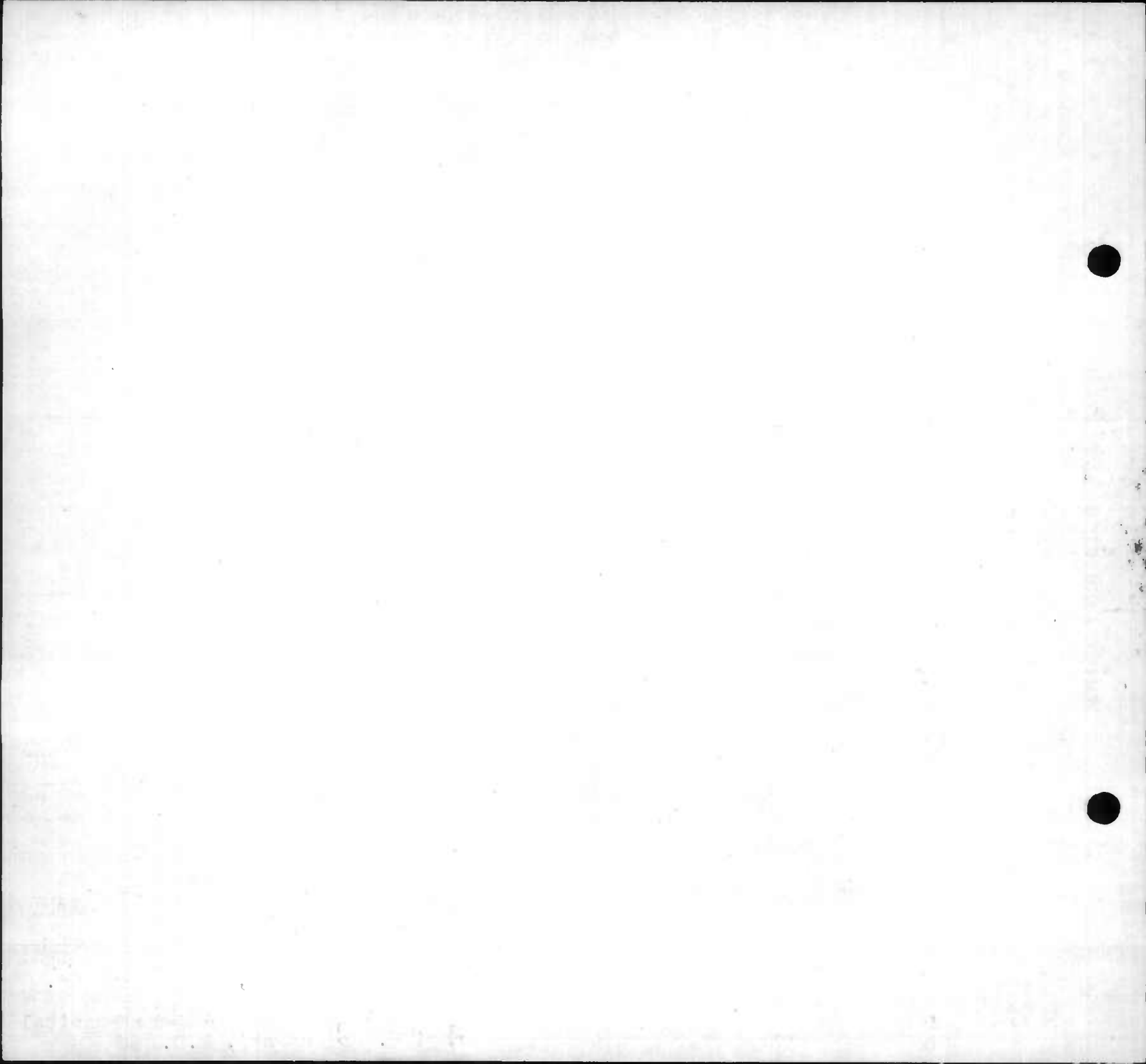
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 4895</u>				
BIRTH NO. <u>65 4895</u>					2. DATE AND HOUR OF DEATH <u>May 6-1965</u>				
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) <u>Steve Mitchellek</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospital</u>					A. STATE <u>Maryland</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>7710 Wynbrook Ave</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>never married</u>			8. DATE OF BIRTH <u>9-12-1899</u>	9. AGE (In years last birthday) <u>65</u>	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosp. work</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Perry Point Hosp. Baltimore, Md</u>			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Martin Mitchellek</u>					14. MOTHER'S MAIDEN NAME <u>A. Novakowski</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>677121781</u>		17. INFORMANT <u>Mrs Rose Scrivani 7004 Brentwood</u>		
					ADDRESS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I T 163X</u> <u>Acute coronary thrombosis</u>					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO				
					(B) DUE TO				
					(C) DUE TO				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Carcinoma of Lung (pneumonia 1962)</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>May 6, 1965</u> , that (I) (we) last saw the deceased alive on <u>May 6, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Lester Leis</u>					M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>5/8/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>LESTER LEIS</u>					23D. ADDRESS <u>M.D.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-10-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Mary</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Tarkenton</u>			25C. FUNERAL DIRECTOR <u>Walter Dabrowski</u>			ADDRESS <u>1005 Dandale Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH					Registered No. 65 4896						
BIRTH NO. 65-13723 4896											
M.E. CASE NO.											
1. NAME OF DECEASED (Type or Print) Baby Bay Bush					2. DATE AND HOUR OF DEATH 5/4/65 5:05 A.M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Harford.						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Hospital For The Women of Md.					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air 6232						
D. STREET ADDRESS (If rural, give location) 6 Dublin Way											
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH 5/4/65		9. AGE (In years last birthday) 2 50			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Joseph (NAN) Bush					14. MOTHER'S MAIDEN NAME Opal Lorraine Sayers						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. None		17. INFORMANT Mother's Adm. Sheet			ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) PREMATURITY PROLAPSED CORD					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/4 1965 to 5/4 1965, that (I) (we) last saw the deceased alive on 5/4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Ernest H. Peterson					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 5/4/65			
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D. D/4						
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			24B. DATE 5/7/65		24C. NAME OF CEMETERY or CREMATORY Womens Hospital			24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965			25B. NAME OF REGISTRAR Robert E. Fink			25C. FUNERAL DIRECTOR Dragi M. Jovanovski, M.D.			ADDRESS Womens Hospital		

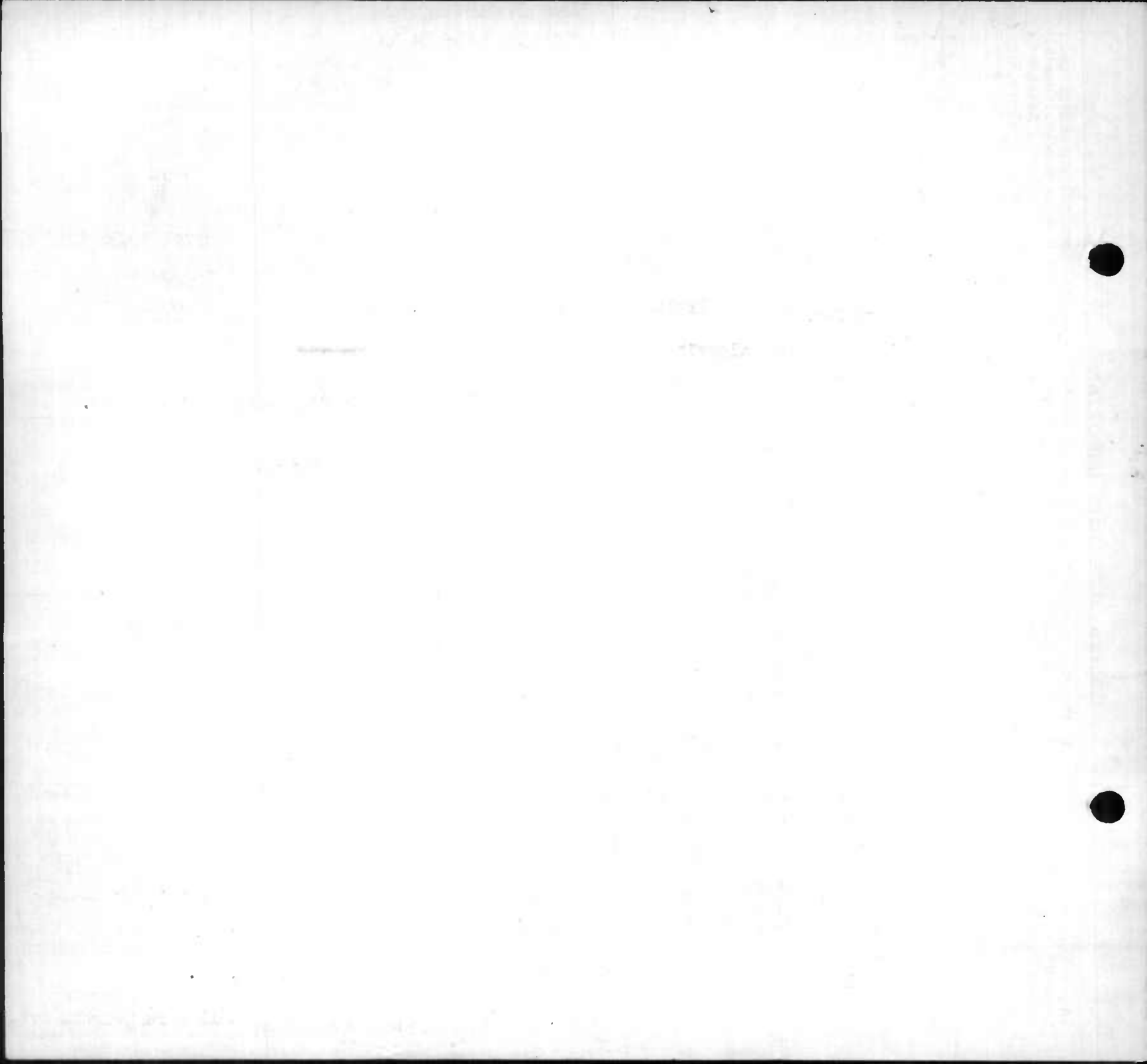




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

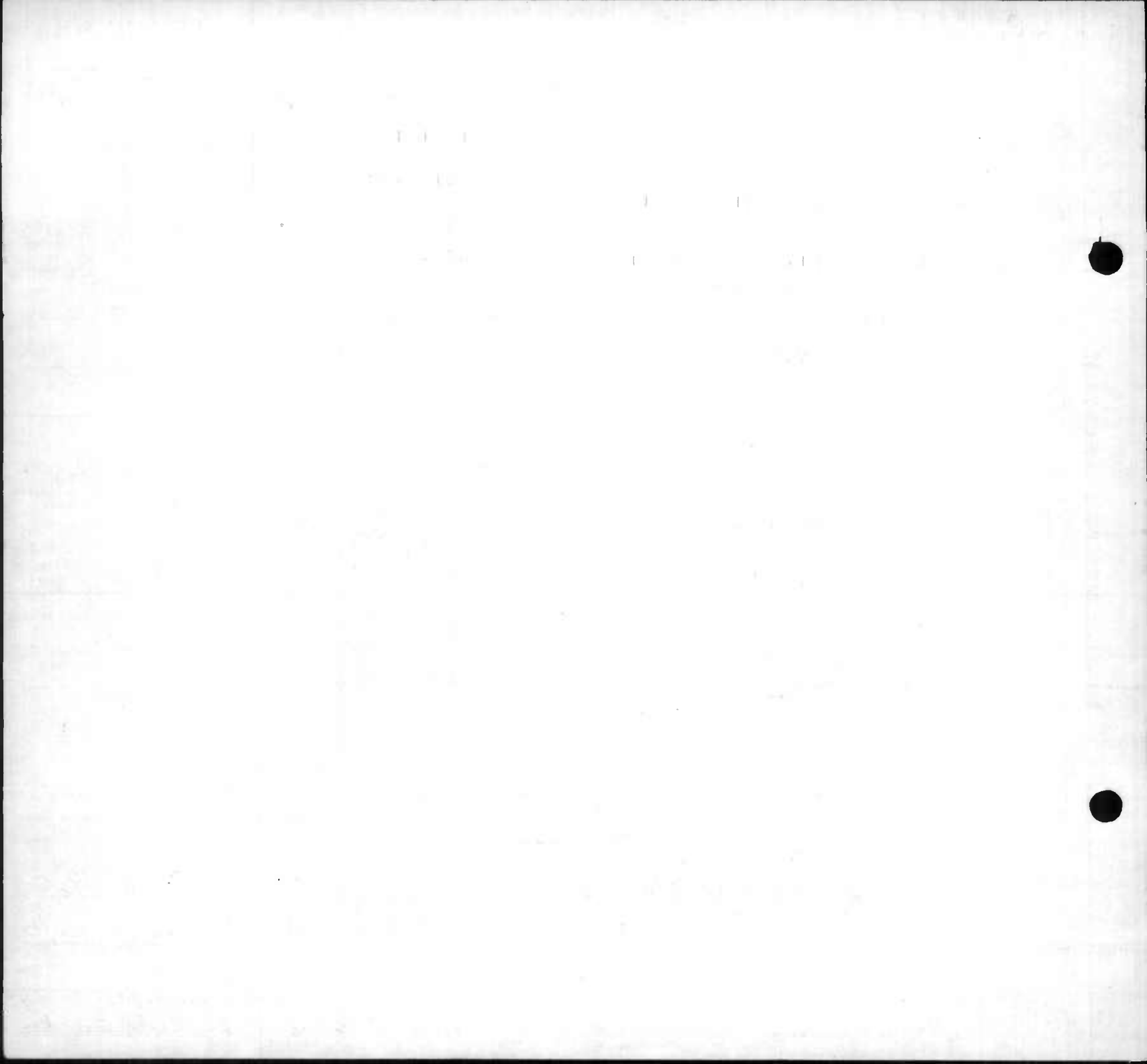
BALTIMORE CITY HEALTH DEPARTMENT									
65 4897 CERTIFICATE OF DEATH					Registered No. 65 4897				
BIRTH NO. 65 4897					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>VALENZIA, ANDREW.</b>					2. DATE AND HOUR OF DEATH <b>5/7/65 4:45 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Lutheran Hospital of Md.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto. 27 MD.</b> D. STREET ADDRESS (If rural, give location) <b>2005 Westwood Ave.</b>				
5. SEX <b>Male</b>	6. RACE <b>white.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/10/1973</b>	9. AGE (In years last birthday) <b>91</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fruit &amp; Produce</b>		11. BIRTHPLACE (State or foreign country) <b>Cefalu, Sicily</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Leo Valenzia</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>THERESA (wife) 2005 Westwood Ave.</b>					
18. <b>434.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>congestive heart failure.</b>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>4/11/65</b> 19 to <b>5/7/65</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>5/7/65</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>S. Rajasee</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/7/65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Soreesh H. Rajasee</b>				23D. ADDRESS M.D. <b>Lutheran Hospital of Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/11/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>G. Vernon Gannon</b>		ADDRESS <b>4611 Park Heights Ave</b>			



FUNERAL DIRECTOR: IMPORTANT

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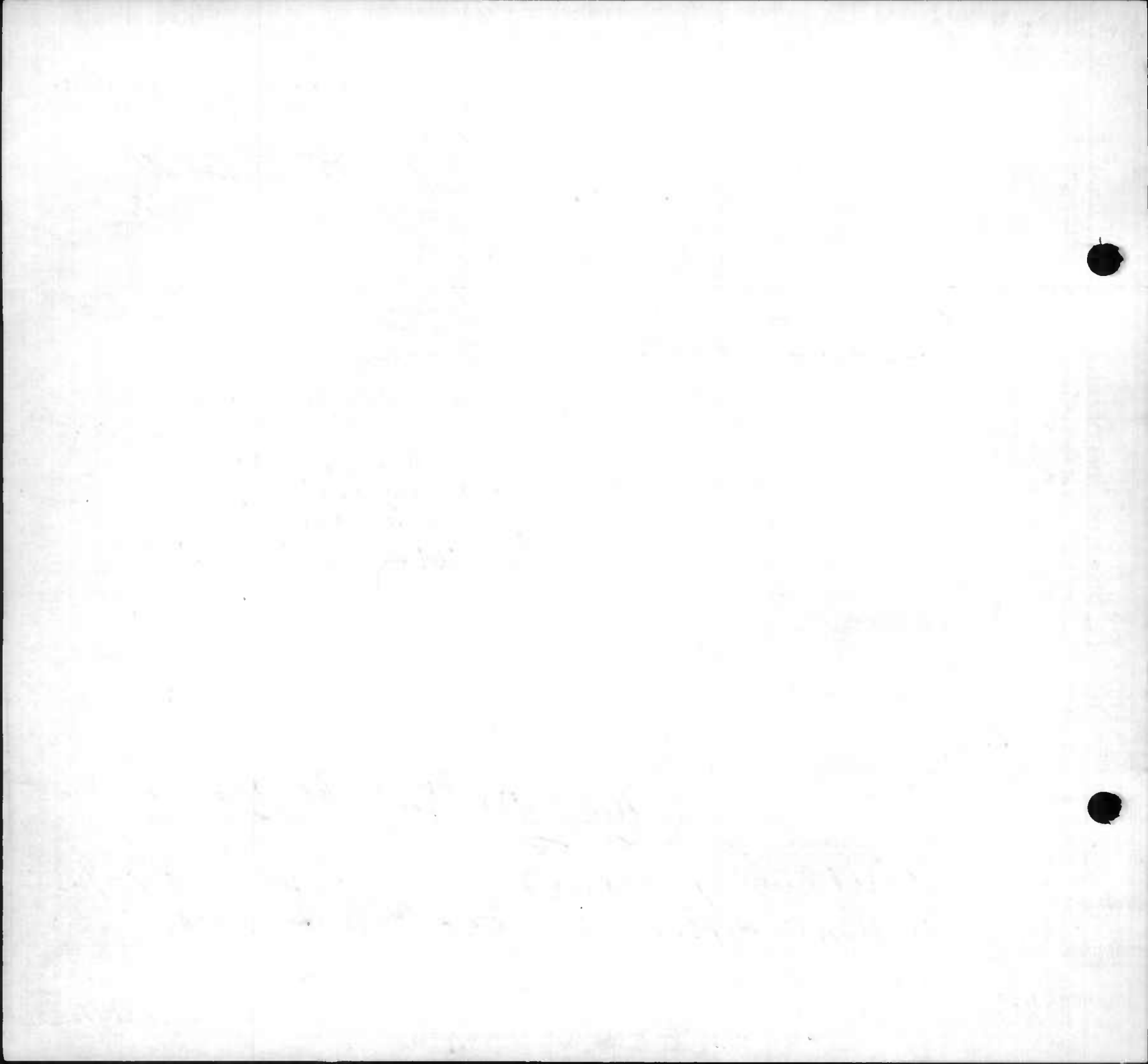
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4898</b>	
65 4898				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				<b>Charles Taylor</b>	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
<b>3 May 1965 7 55 P.M.</b>		<b>THE JOHNS HOPKINS HOSPITAL</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
<b>VIRGINIA</b>		<b>THE JOHNS HOPKINS HOSPITAL</b>			
5. CITY OR TOWN (If outside city limits, write RURAL and give township)		6. STREET ADDRESS (If rural, give location)			
<b>ARLINGTON</b>		<b>5515 18th Road N.</b>			
7. SEX		8. RACE		9. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
<b>MALE</b>		<b>WHITE</b>		<b>MARRIED</b>	
10. DATE OF BIRTH		11. AGE (In years last birthday)		12. CITIZEN OF WHAT COUNTRY?	
<b>5-18-98</b>		<b>66</b>		<b>U.S.A.</b>	
13. BIRTHPLACE (State or foreign country)		14. MOTHER'S MAIDEN NAME		15. FATHER'S NAME	
<b>Copperas Cove, Tex</b>		<b>Effie McGuire</b>		<b>CHARLES TAYLOR</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS	
		<b>James R. Taylor (son)</b>		<b>3 May 1965</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		20. CAUSE OF DEATH		21. INTERVAL BETWEEN ONSET AND DEATH	
<b>199.2 I</b>		<b>Pneumonia</b>		<b>3 dys</b>	
<b>ANTECEDENT CAUSES</b>		<b>Metastatic Carcinoma</b>		<b>6 mos</b>	
<b>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</b>		<b>Site unknown</b>		<b>~10 yrs</b>	
<b>II</b>		<b>Benign Prostatic Hypertrophy</b>		<b>3 yrs</b>	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		23. DATE OF OPERATION		24. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		<b>22</b>		<b>YES</b>	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		29. INJURY OCCURRED		30. HOW DID INJURY OCCUR?	
		<b>While At Work</b>			
31. I certify that (this hospital) attended the deceased from <b>6 April 1965</b> to <b>3 May 1965</b> , that (we) last saw the deceased alive on <b>3 May 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.		32. SIGNATURE		33. DATE SIGNED	
<b>L.J. Buckels M.D.</b>		<b>3 May 1965</b>			
34. PHYSICIAN'S NAME (Type)		35. ADDRESS		36. DATE	
<b>L.J. Buckels, M.D.</b>		<b>Johns Hopkins Hospital, Baltimore, Md.</b>		<b>5/7-65</b>	
37. BURIAL CREMATION, REMOVAL (Specify)		38. NAME OF CEMETERY or CREMATORY		39. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>ARLINGTON NATIONAL</b>		<b>ARLINGTON, Va.</b>	
40. DATE REC'D BY HEALTH DEPT.		41. NAME OF REGISTRAR		42. FUNERAL DIRECTOR	
<b>MAY 10 1965</b>		<b>Robert E. Taylor</b>		<b>JES FUNERAL HOME</b>	
				<b>ARLINGTON, Va.</b>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 4899</u>	
BIRTH NO. <u>65 4899</u>		CERTIFICATE OF DEATH	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lucy Mills</u>		<u>May 4, 1965</u> <u>12.10 A.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Midtown Home</u> <u>808 St. Paul St.</u>		A. STATE <u>Md.</u> B. COUNTY <u>20-06</u>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>509 S. Longwood St.</u>	
		D. STREET ADDRESS (If rural, give location) <u>Balto. 23</u> <u>Md.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/14/82</u>
		9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Isaac Halton</u>	
14. MOTHER'S MAIDEN NAME <u>Martha ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>224092853 D</u>		17. INFORMANT ADDRESS <u>Naughton (8307 Birkfield Rd.)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u> <u>Due to Myocardial Infarction</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Anteromedullary CVD</u> <u>Generalized Arteriosclerosis</u> <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 2</u> 19 <u>64</u> to <u>May 4</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>William D Appleford</u>		23B. DATE SIGNED <u>5/4/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>William D Appleford</u>		23D. ADDRESS M.D. <u>5501 Park Heights Av.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/6/65</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber</u>	
25C. FUNERAL DIRECTOR <u>Connelly</u>		ADDRESS <u>300 Macell Ave. Balto. 21</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4900</span>	
65 4900				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MARGARETB SKUSZKA		May 6 - 1965 6:55 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  SOUTH BALTIMORE GENERAL HOSPITAL			A. STATE Maryland B. COUNTY Baltimore City		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)			D. STREET ADDRESS (If rural, give location)		
Baltimore City			1521 Blmtree Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W		March 27-1917	48	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None		NEVER MARRIED		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Onofry Skuszka			Tena Papisz		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				1521 Tena Skuszka - 1521 Blmtree Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> 19 <u>63</u> to <u>April 29</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>65</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<u>Morton M. Krieger</u>				May 6, 1965	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Morton M. Krieger			5010 A Ritchie Hwy. Balto. 25, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5/10/65		HOLY CROSS CEMETERY	
				Anne Arundel County-Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1965		Robert E. Taylor M.D.		William S. Fialkowski 2007 Eastern Ave.	

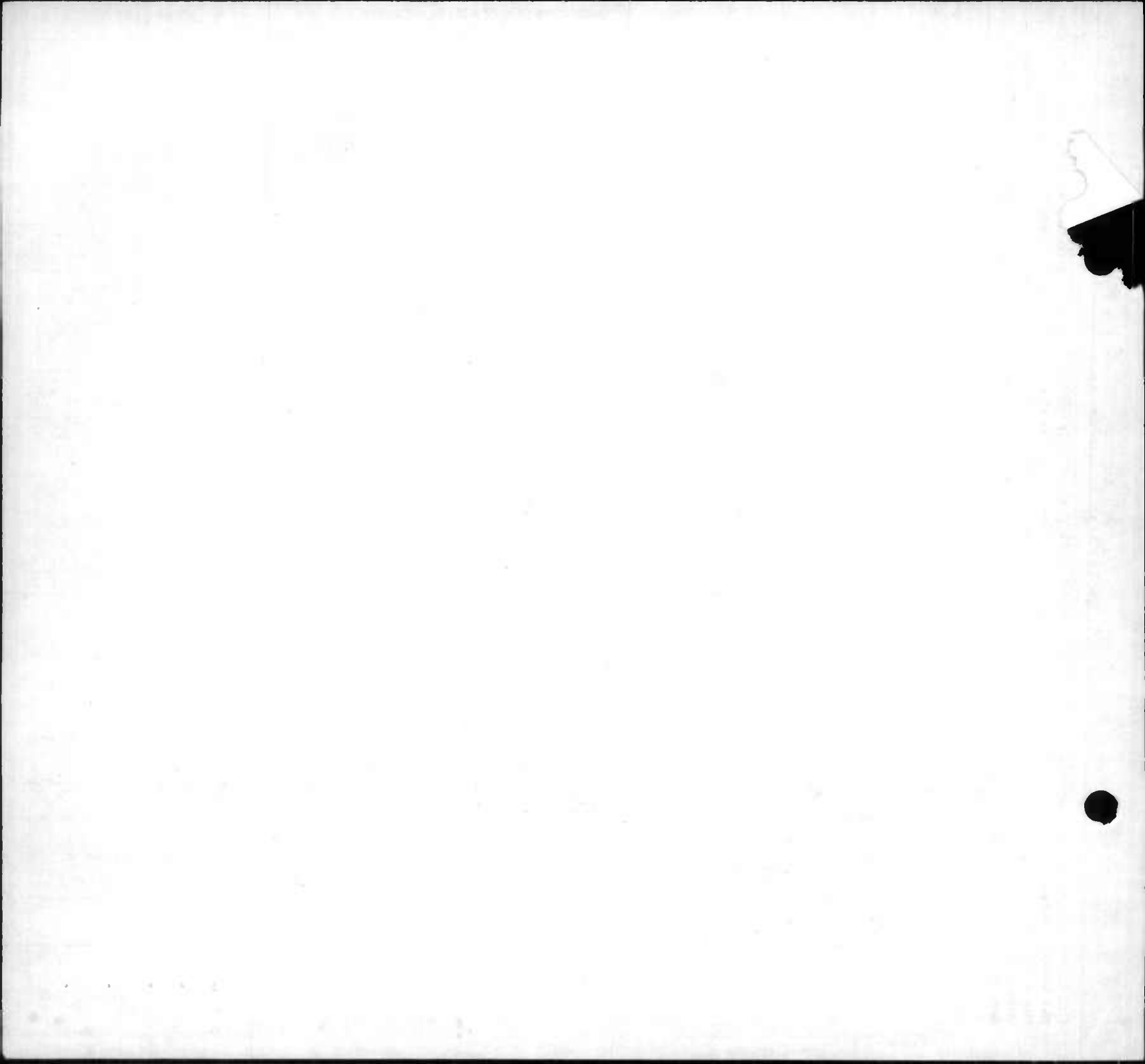




# FUNERAL DIRECTOR: IMPORTANT

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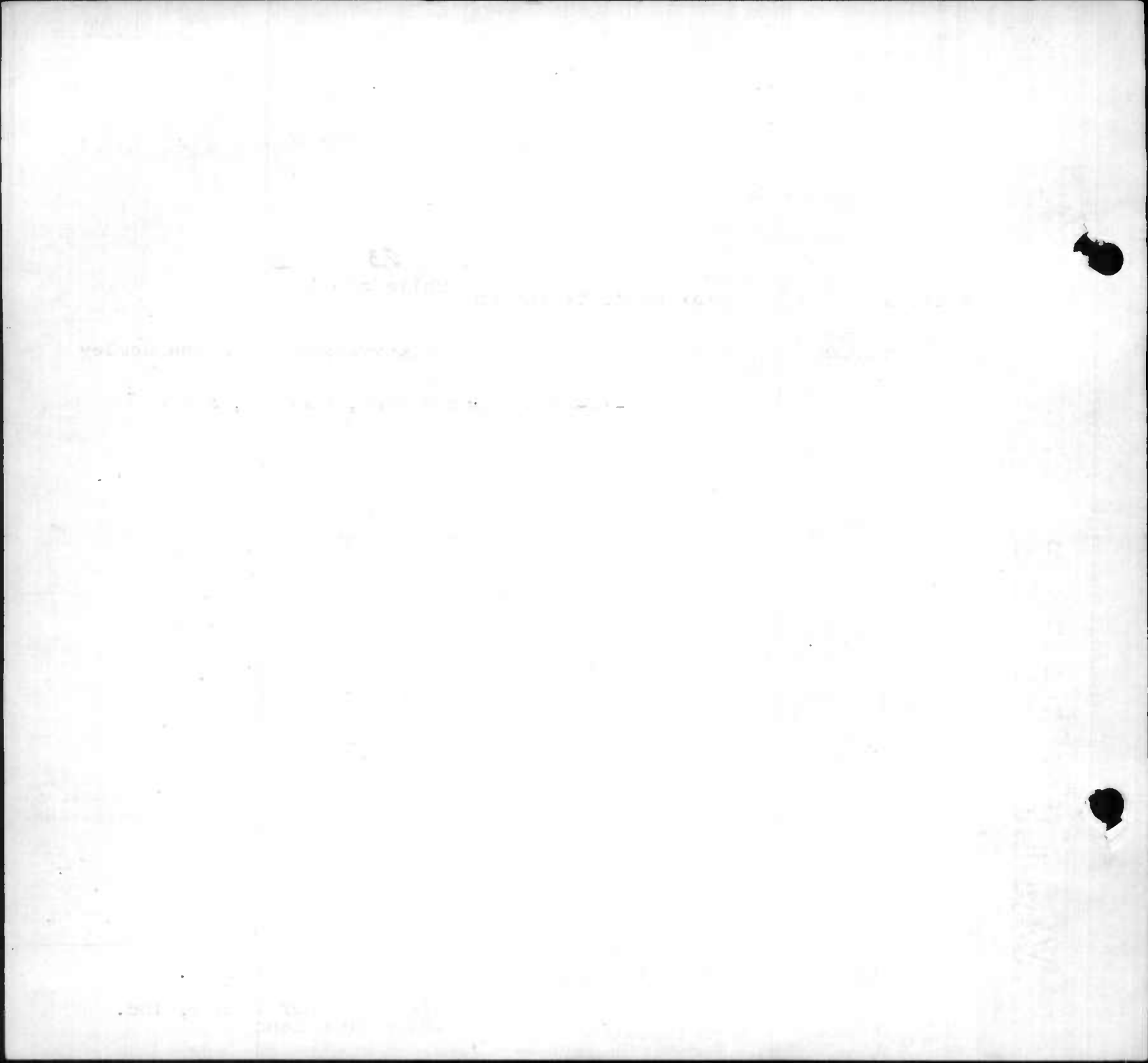
Baltimore City Health Department				Registered No.	
BIRTH NO.		65 4901		65 4901	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Rutherford, Fannie E.			May 7, 1965 3:25 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
University Hospital			Md. Baltimore City		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			Baltimore		
			D. STREET ADDRESS (If rural, give location)		
			1809 Light Street		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
F	W	Widow	12/11/09	55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			W. Virginia		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Sherman Gray			Mary Whittington		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			212-34-6458		Margaret Eader 1812 Light St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) DUE TO		
ANTECEDENT CAUSES			Septic Shock		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO		
			Ascending Cholangitis		
			(C) DUE TO		
			Carcinoma, Biliary Tree		
II			INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			4 hrs.		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
14/29/65			OBSTRUCTIVE JAUNDICE		NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/20 19 65 to 5/7 19 65, that (I) (we) last saw the deceased alive on 5/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE					23B. DATE SIGNED
Philip J. Ferris, MD M.D.					5/7/65
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS
Philip J. Ferris, MD M.D.					University Hospital
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5 10 65		Cedar Hill	
				24D. LOCATION (City, town, or county) (State)	
				Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1965		Robert E. Taylor, M.D.		McRally Ford Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4902		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65 4902	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>BLANCHE MARIE HAND</b>		2. DATE AND HOUR OF DEATH <b>5/16/65 10. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-34</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>FRANKLIN SQUARE HOSP</b>		D. STREET ADDRESS (If rural, give location) <b>5129 WRIGHT AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>2/17/03</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Marion Kurtz Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James HOPKINS</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Remley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-14-8988</b>		17. INFORMANT ADDRESS <b>George Hand, husband, above</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>422.11 ASVD</b>		CAUSE OF DEATH (A) DUE TO <b>congestive failure</b> (B) DUE TO <b>hypertension? blood dyscrasia</b> (C)		INTERVAL BETWEEN ONSET AND DEATH	
19. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> 19 <b>65</b> to <b>5/16</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/16</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>P.E. BRION</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED <b>5/16/65</b>		23C. PHYSICIAN'S NAME (Type) <b>P.E. BRION</b> M.D.		23D. ADDRESS <b>FRANKLIN SQUARE HOSP</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25D. ADDRESS <b>3331 Brehms Lane</b>			



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 4903</b>	
BIRTH NO. <b>65 4903</b>		CERTIFICATE OF DEATH	
M.E. CASE NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LILLIAN SEWARD</b>		<b>May 5, 1965 11:15 p M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>House in the Pines Belair Rd.</b>		A. STATE <b>Md. 21213</b> B. COUNTY <b>8-01</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>3007 Belair Rd.,</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>Jan. 6, 1877</b>
		9. AGE (In years last birthday) <b>88</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hagel Bakery</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John Manley</b>		14. MOTHER'S MAIDEN NAME <b>Frances Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>O. Joseph Keagle, son, above</b>
18. <b>443X1</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Myocardial Exhaustion</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hypertensive Cardiovascular</b>	
		(C) <b>Heart disease</b>	
		(D) <b>Seizure</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>24 hr.</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 1965</b> to <b>5-5-1965</b> , that (I) (we) last saw the deceased alive on <b>5-5-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William L. Fearing</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <b>5-7-65</b>
23C. PHYSICIAN'S NAME (Type) <b>William L. Fearing</b>		23D. ADDRESS <b>3025 Belair Rd, Balt - 13 Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/8/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Fearing</b>	25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
		ADDRESS <b>3331 Brehms Lane</b>	

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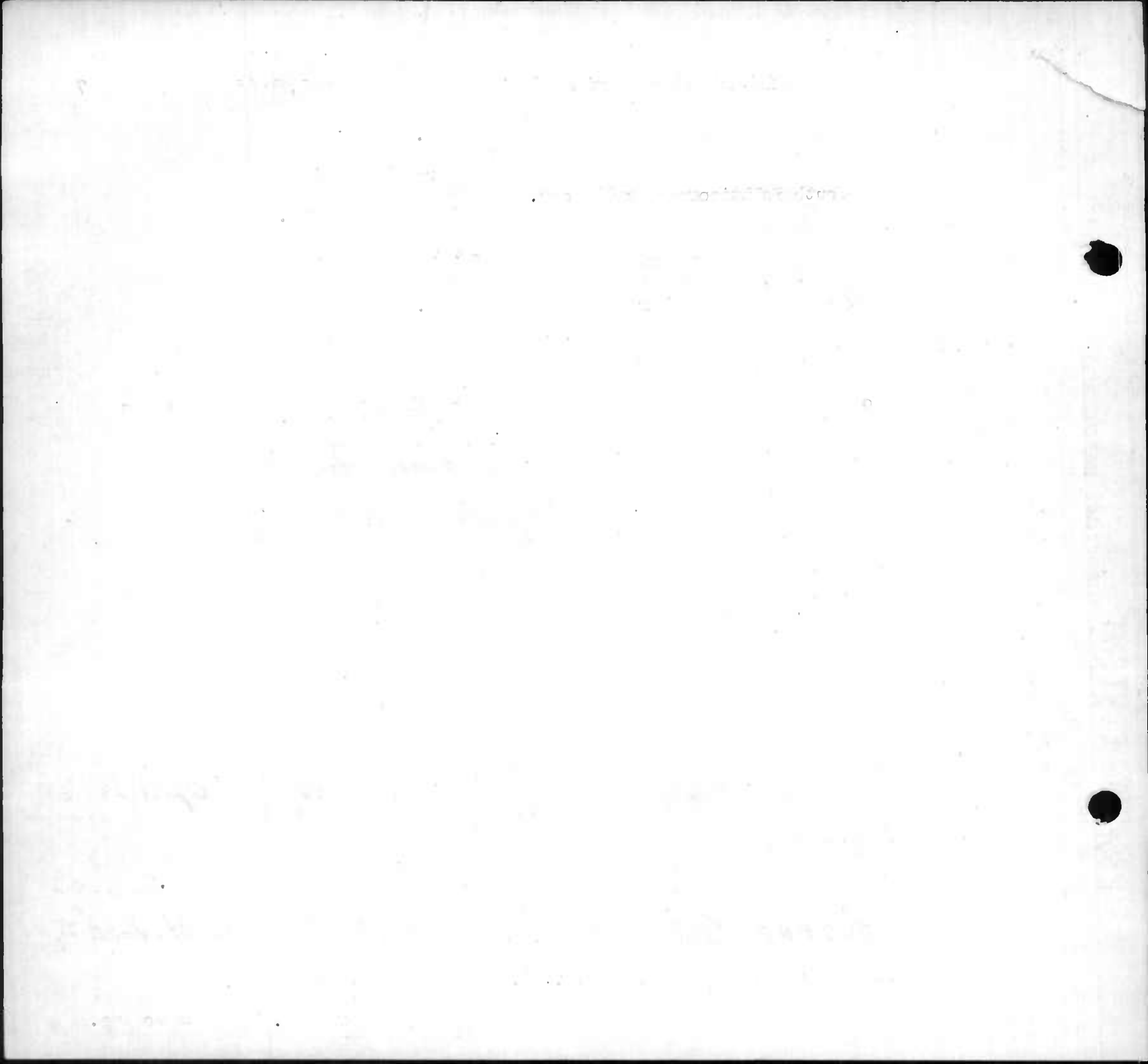
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 4904		CERTIFICATE OF DEATH		65 4904	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Richard Edward Varina		May 3, 1965 7A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
		Md.			
South Baltimore General Hosp.		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Brooklyn Park			
		D. STREET ADDRESS (If rural, give location)			
		308 Townsend Ave.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
M	WHITE	Married	2/7/95	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Retired		Baker	Md.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Unk			Unk		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
No			Family		Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO			Cardiac Failure
		(B) DUE TO			Hypertensive Atherosclerotic Disease
		(C) DUE TO			
19. ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from Jan 1956 to April 23, 1965, that (I) (we) last saw the deceased alive on 4-23-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Eugene Schnitzer				5-3-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
EUGENE SCHNITZER		3904 S. Hanover St. Balt. 25 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	5/5/65	Loudon Pk. Cem.		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1965		E. J. Taylor		McCutty Funeral Hm. 237 Patspeco Ave.	





# FUNERAL DIRECTOR: IMPORTANT

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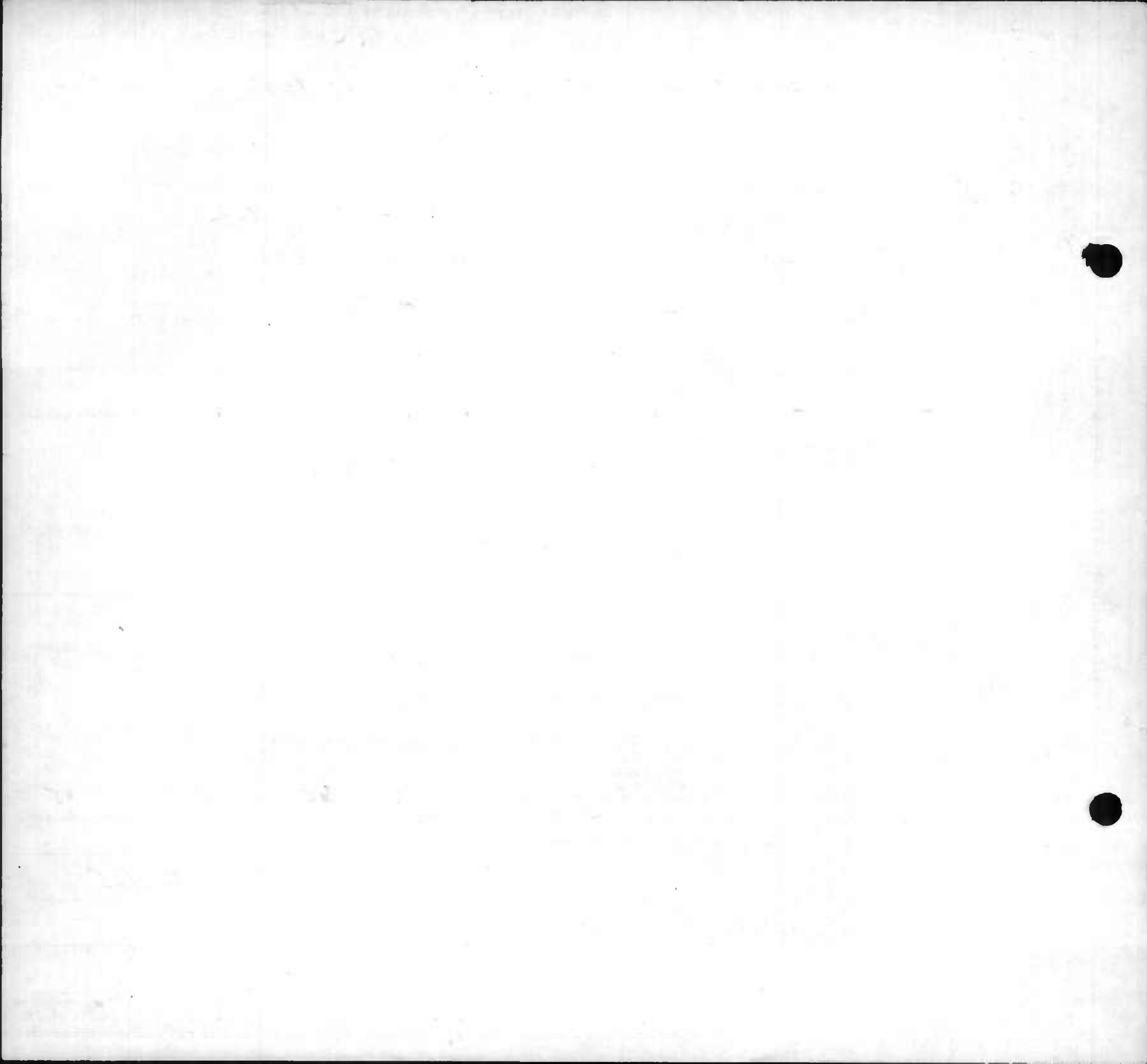
BIRTH NO. 65 4905				BALTIMORE CITY HEALTH DEPARTMENT		65 4905	
M.E. CASE NO.				CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <u>William M. Hohman</u>				2. DATE AND HOUR OF DEATH <u>5/6/65</u> <u>3:15 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) <u>University Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Randallstown</u> D. STREET ADDRESS <u>3506 Offutt Rd</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7/11/85</u>	9. AGE (In years last birthday) <u>79</u>	If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank Hohman</u>				14. MOTHER'S MAIDEN NAME <u>Esther Clappett</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-2-0501</u>		17. INFORMANT <u>Hospital Chart</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Peritonitis</u>				CAUSE OF DEATH (A) <u>Peritonitis</u> DUE TO (B) <u>Prob. Rupt. of peptic ulcer</u> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>96 hrs.</u> <u>96 hrs.</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>5/6/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>this hospital</u> attended the deceased from <u>5/4</u> 19 <u>65</u> to <u>5/6</u> 19 <u>65</u> , that (I) <u>we</u> lost saw the deceased alive on <u>5/6</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death.							
23A. SIGNATURE <u>Peter Mac Murray</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/6/65</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Family Cemetery</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Farley</u>		25C. FUNERAL DIRECTOR <u>Loring Byers - 8728 Liberty Rd</u>		ADDRESS <u>Randallstown</u>	



# FUNERAL DIRECTOR: IMPORTANT

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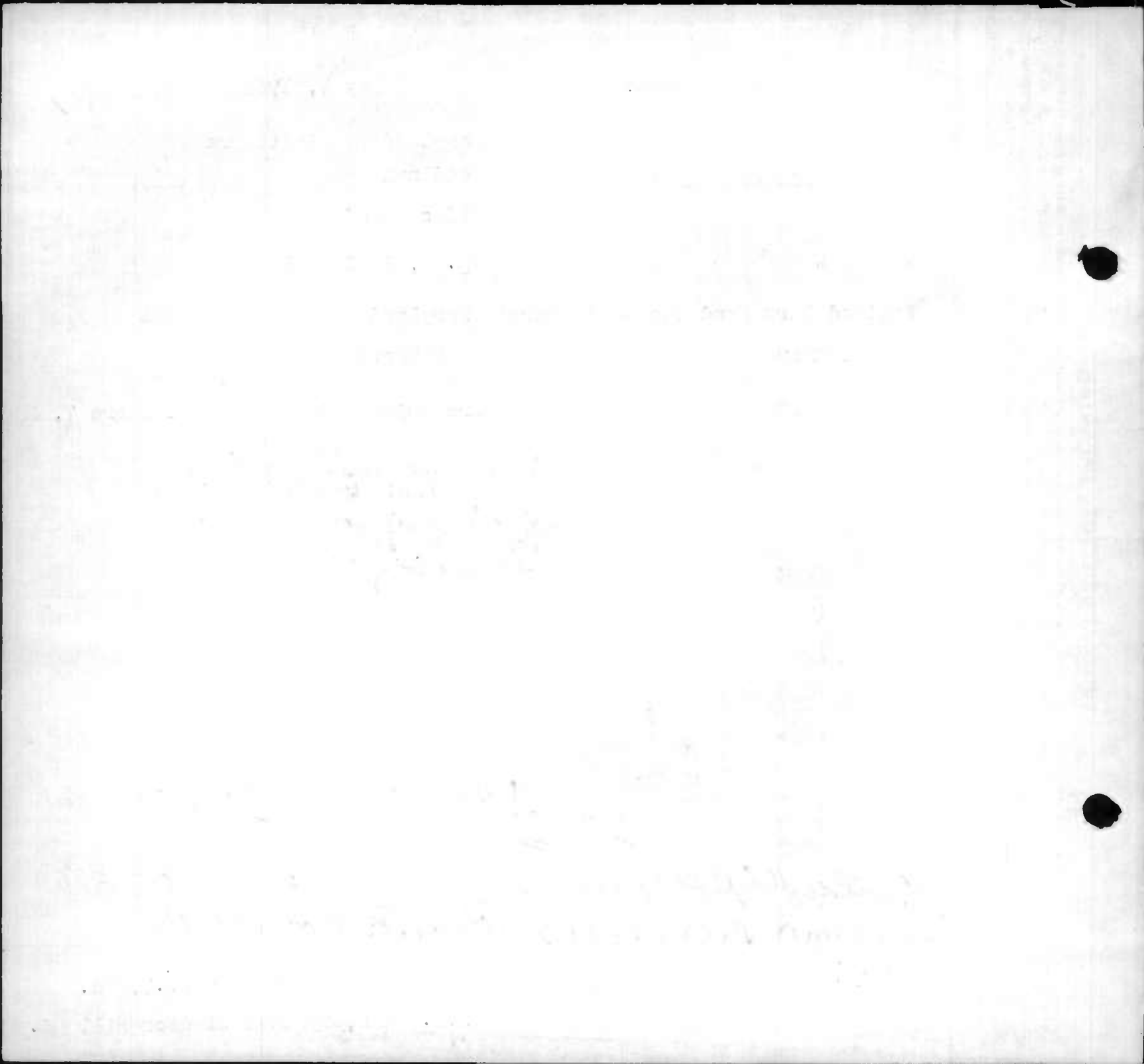
BALTIMORE CITY HEALTH DEPARTMENT									
65 4906					65 4906				
BIRTH NO.					Registered No.				
1. NAME OF DECEASED (Type or Print) <u>Sophia Blachowicz</u>					2. DATE AND HOUR OF DEATH <u>5/7/65</u> <u>11 15/P.</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>Balto</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai</u>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto</u> <u>33-00</u>				
D. STREET ADDRESS (If rural, give location) <u>8832 Victory Ave</u>									
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-5-82</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Peter Midura</u>			14. MOTHER'S MAIDEN NAME <u>Anna Lasek</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>			16. SOCIAL SECURITY NO. <u>213-18-3087</u>		17. INFORMANT <u>Mrs. Lee Sheldon</u>				
			ADDRESS <u>8832 Victory Avenue</u>						
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>					CAUSE OF DEATH <u>24 hrs</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HASCVD</u>					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>5-7-65</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>			21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>				
22. I certify that <u>(this hospital)</u> attended the deceased from <u>5-7</u> 19 <u>65</u> to <u>5-7</u> 19 <u>65</u> , that <u>(we)</u> last saw the deceased alive on <u>5-7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did)</u> <del>(did not)</del> view the body after death.									
23A. SIGNATURE <u>Richard Gerald Shugerman</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/7/65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Richard G Shugerman, MD</u>					23D. ADDRESS <u>Sinai Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/11/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus</u>		24D. LOCATION (City, County, State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Talley</u>			25C. FUNERAL DIRECTOR ADDRESS <u>M.F. SADOWSKI &amp; SONS, 1808 Eastern Ave</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <u>65 4907</u>			
BIRTH NO. <u>65 4907</u>		M.E. CASE NO.								1. NAME OF DECEASED (Type or Print) <u>Charles Sodom</u>		2. DATE AND HOUR OF DEATH <u>May 7, 1965</u> <u>12:50 P.</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Midtown Nursing Home</u>						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Woodlawn</u> D. STREET ADDRESS (If rural, give location) <u>Ridge Road</u>							
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>S</u>		8. DATE OF BIRTH <u>Aug. 6, 1871</u> <u>93</u>		9. AGE (In years last birthday) <u>93</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Hand The Woods Farm</u>						10B. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs Smith Ridge Road Baltimore 7, M</u>							
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <u>Cardio Respiratory Failure</u> DUE TO <u>Chronic Heart Failure</u> (B) <u>Arteriosclerotic CVD</u> DUE TO <u>Gen. arteriosclerosis</u> (C) <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH			
						MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>6</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No)  20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  21F. HOW DID INJURY OCCUR?  22. I certify that (I) (this hospital) attended the deceased from <u>Jan 8 1965</u> to <u>May 7 1965</u> , that (I) (we) last saw the deceased alive on <u>May 7 1965</u> and that (in my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <u>William Appleford</u> 23C. PHYSICIAN'S NAME (Type) <u>William Appleford</u>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/8/65</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>						24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn Balto. 7, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>J. T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4908</u>	
BIRTH NO. <u>65 4908</u>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <u>5 7 65</u> <u>4:17A</u> M.	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE M MOORE</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>16-08</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 6-7-65</b> FULL NAME OF HOSPITAL OR INSTITUTION <u>ST AGNES HOSPITAL</u> (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	
8. DATE OF BIRTH <u>2 22 93</u>		9. AGE (In years last birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHAREHOUSE &amp; BROKERAGE</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JULIAN MOORE</u>		14. MOTHER'S MAIDEN NAME <u>MARY MANLY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216 03 0452</u>		17. INFORMANT <u>Miss Helen H. Jones</u> ADDRESS <u>Rel 1236</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.01</u> DUE TO <u>Bronchopneumonia @ lung.</u> <u>Lobar pneumonia @ lung.</u> DUE TO <u>As H P &amp; chs CHF.</u>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>5 5</u> 19 <u>65</u> to <u>5 7</u> 19 <u>65</u> , that (I) ( <u>we</u> ) lost saw the deceased alive on <u>5 7</u> 19 <u>65</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel J. [Signature]</u> M.D.				23B. DATE SIGNED <u>5-7-65</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <u>St Agnes Hosp.</u> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u>	
24D. LOCATION (City, town or county) (State) <u>Ba. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>W. H. 4101</u>		ADDRESS <u>Edmondson</u>	

Letter from St. Agnes Hospital  
6-7-65 M.H.



BIRTH NO. 65 4909 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES McGEE

2. DATE AND HOUR PRONOUNCED DEAD

5/6/65 14:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1714 Carswell St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Feb 18, 1899

9. AGE (in years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Guard

10B. KIND OF BUSINESS OR INDUSTRY

Royal Crown  
Bottling Co

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John McGee

14. MOTHER'S MAIDEN NAME

Cora Deaver

1231 Harwall Road

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

81703774

17. INFORMANT

James McGee

ADDRESS

1231 Harwall Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gastro-intestinal hemorrhage, originating  
from esophageal varices

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Laennec Cirrhosis of the liver

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5/7/65

23A. BURIAL CREMATION,  
(Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Robert E. Fairley

LEO G. COOK

1701 N. PATTERS O N

Park Ave

MAILED FOR GIVE

1944

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

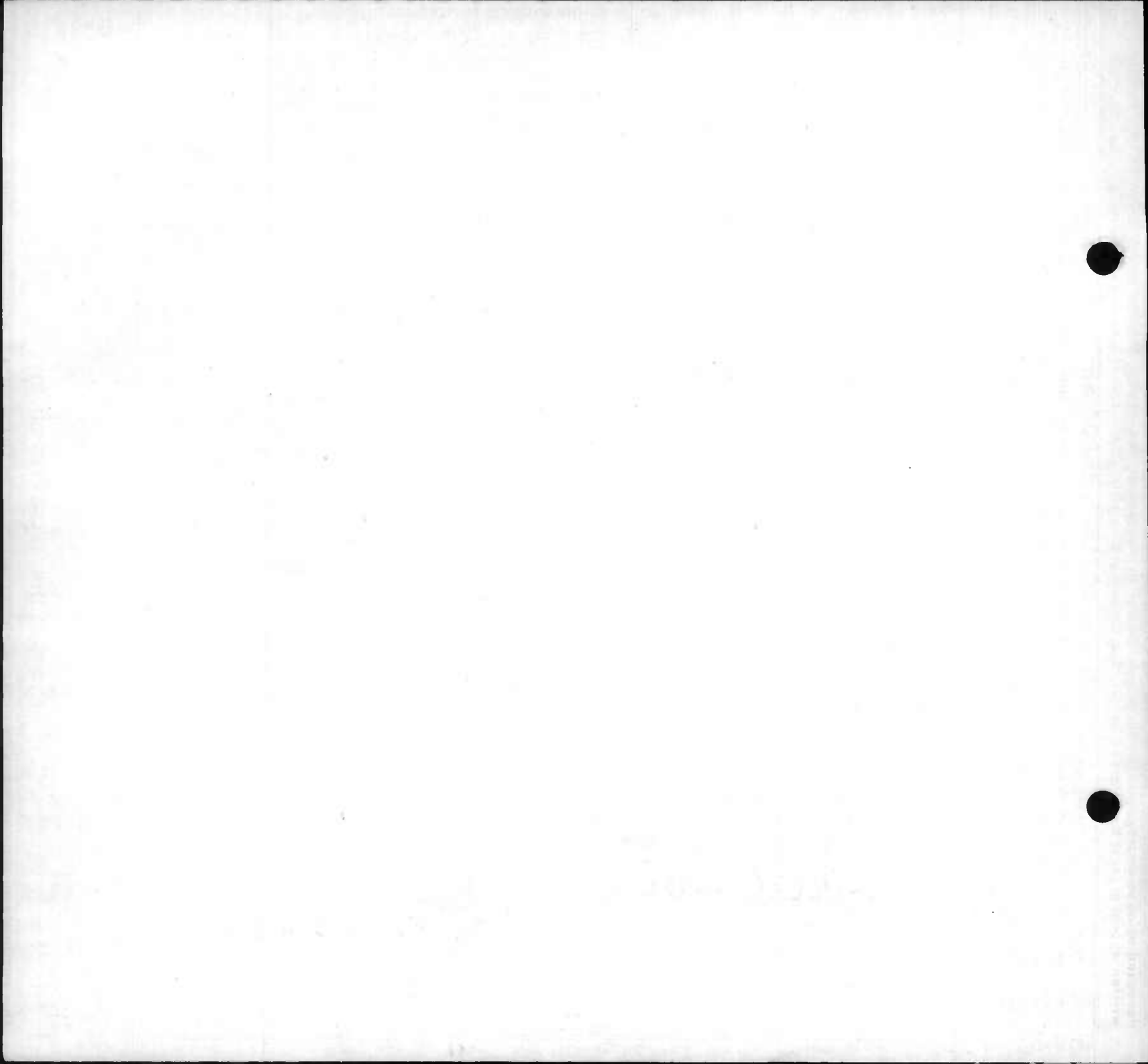
BIRTH NO. 65 4910		BALTIMORE CITY HEALTH DEPT. <b>CERTIFICATE OF DEATH</b>		Registered No. 65 4910	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Eugene Edward Sims</i>		2. DATE AND HOUR OF DEATH <i>5-5-65</i>   <i>6:00</i> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>8730 Loch Raven Blvd.</i>			
5. SEX <i>M</i>	6. RACE <i>Cauc.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>1-21-89</i>	9. AGE (In years last birthday) <i>76</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self-employed</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Charles Henry Sims</i>		14. MOTHER'S MAIDEN NAME <i>Lydia Brown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS <i>215-24-2049</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>422.1 I</i>		CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (C) <i>Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 days.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-28</i> 19 <i>65</i> to <i>5-5</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>5-5</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodney L. Brimhall</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-5-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>RODNEY L. BRIMHALL</i>		23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/8/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Providence Methodist</i>	
24D. LOCATION (City, town, or county) (State) <i>Providence, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John J. Brown</i>	
				ADDRESS <i>Townson</i>	

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

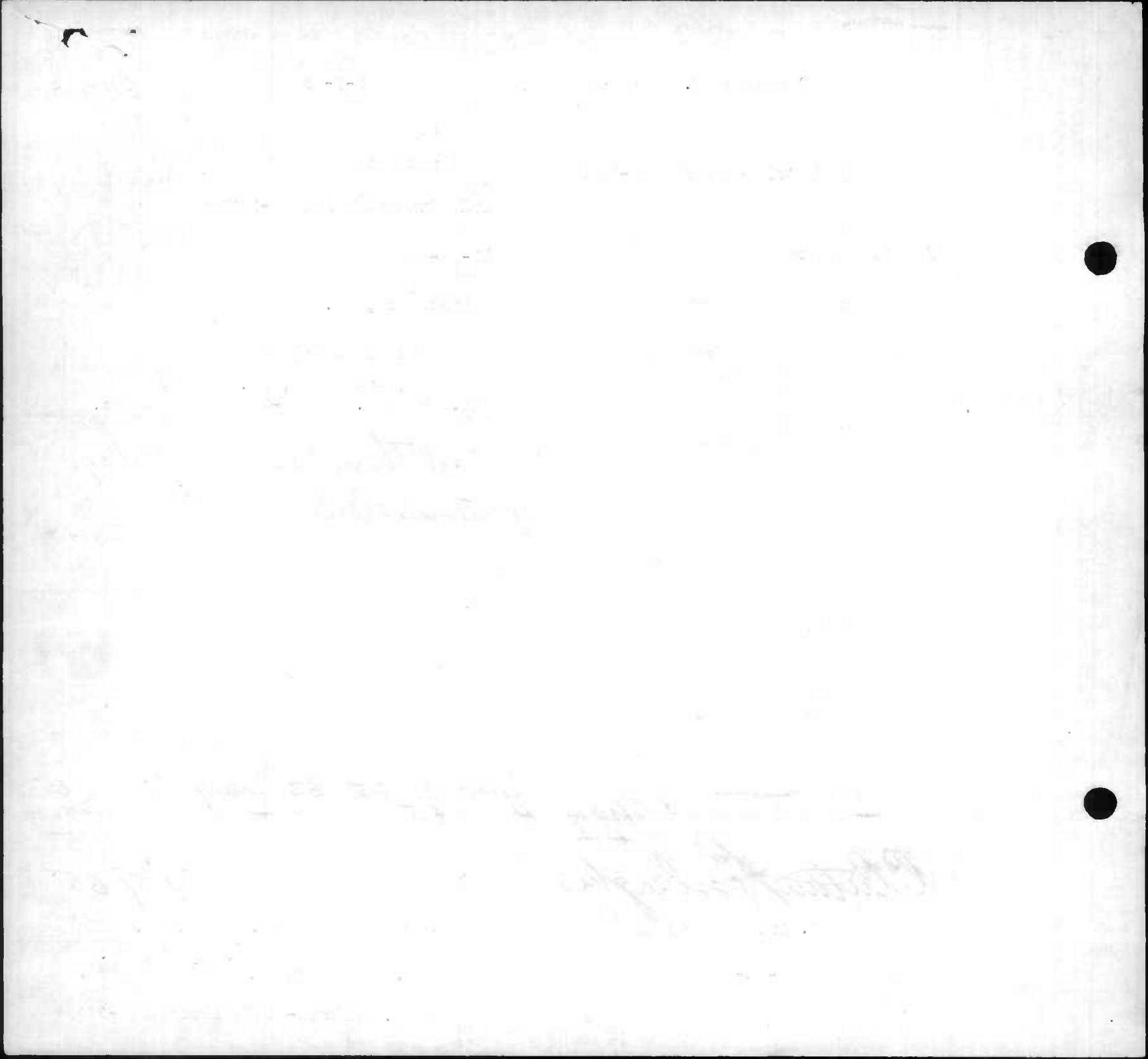
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										Registered No. <b>65 4911</b>
BIRTH NO. <b>65 4911</b>		M.E. CASE NO.								
1. NAME OF DECEASED (Type or Print) <b>MATTHEWS, ROGER</b>					2. DATE AND HOUR OF DEATH <b>MAY 9, 1965 3 A.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SOUTH BALTIMORE GENERAL HOSPITAL 1213 LIGHT STREET, BALTIMORE 30 Md.</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SEVERN 52-00</b> D. STREET ADDRESS (If rural, give location) <b>Box 726 - RTE 2</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>1-13-15</b>	9. AGE (In years lost birthday) <b>50</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SELF EMPLOYED</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>HARRONS A.A. Co MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>NICHOLAS MATTHEWS</b>					14. MOTHER'S MAIDEN NAME <b>ROSIE OLIVER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-01-2890</b>		17. INFORMANT <b>BEATRICE MATTHEWS DECEASED</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>144X I</b> <b>Neoplasm of Palate</b>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION <b>5/9/65</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4/30 1965</b> to <b>5/9 1965</b> , that (I) (we) last saw the deceased alive on <b>5/9 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>[Signature]</b>						M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/9/65</b>		
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D. <b>So. Balto Gen Hosp.</b>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)				
<b>Burns</b>		<b>5/12/65</b>		<b>Arbutus Memorial Park - Baltimore - Balto Co. Md</b>		<b>Arbutus - Balto Co. Md</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>			25C. FUNERAL DIRECTOR <b>Manfred P. Pappas</b>			ADDRESS <b>638 N. Green St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4912					CERTIFICATE OF DEATH				
M.E. CASE NO.					Registered No. 65 4912				
1. NAME OF DECEASED (Type or Print) Gertrude C. Chambers					2. DATE AND HOUR OF DEATH 5-7-65 6:00 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1917 Grinnalds Avenue-21230					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 1917 Grinnalds Avenue-21230				
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 12-30-86	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hankins					14. MOTHER'S MAIDEN NAME Catherine Farrell				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Parkville, Md. 21234 ADDRESS Mrs. Ethel M. Houser-3028 Linwood Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Thrombosis (B) Hypertensive + Arteriosclerotic C-V-D (C) INTERVAL BETWEEN ONSET AND DEATH 9 days (3 yrs +)					19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this doctor) attended the deceased from March 25 1963 to May 7 1965, that (I) lost saw the deceased alive on May 4 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE C. Arthur Rossberg					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stelf Phys. <input type="checkbox"/>		23B. DATE SIGNED 5/8/65		
23C. PHYSICIAN'S NAME (Type) C. Arthur Rossberg					23D. ADDRESS M.D. 2436 Washington Blvd., Balto., Md. 21230				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-65		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Memorial Pk.		24D. LOCATION (City, town or county) (State) Balto. County, Md. Padonia Rd. & Gibbons Blvd.			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965			25B. NAME OF REGISTRAR Robert E. Faldut			25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229			

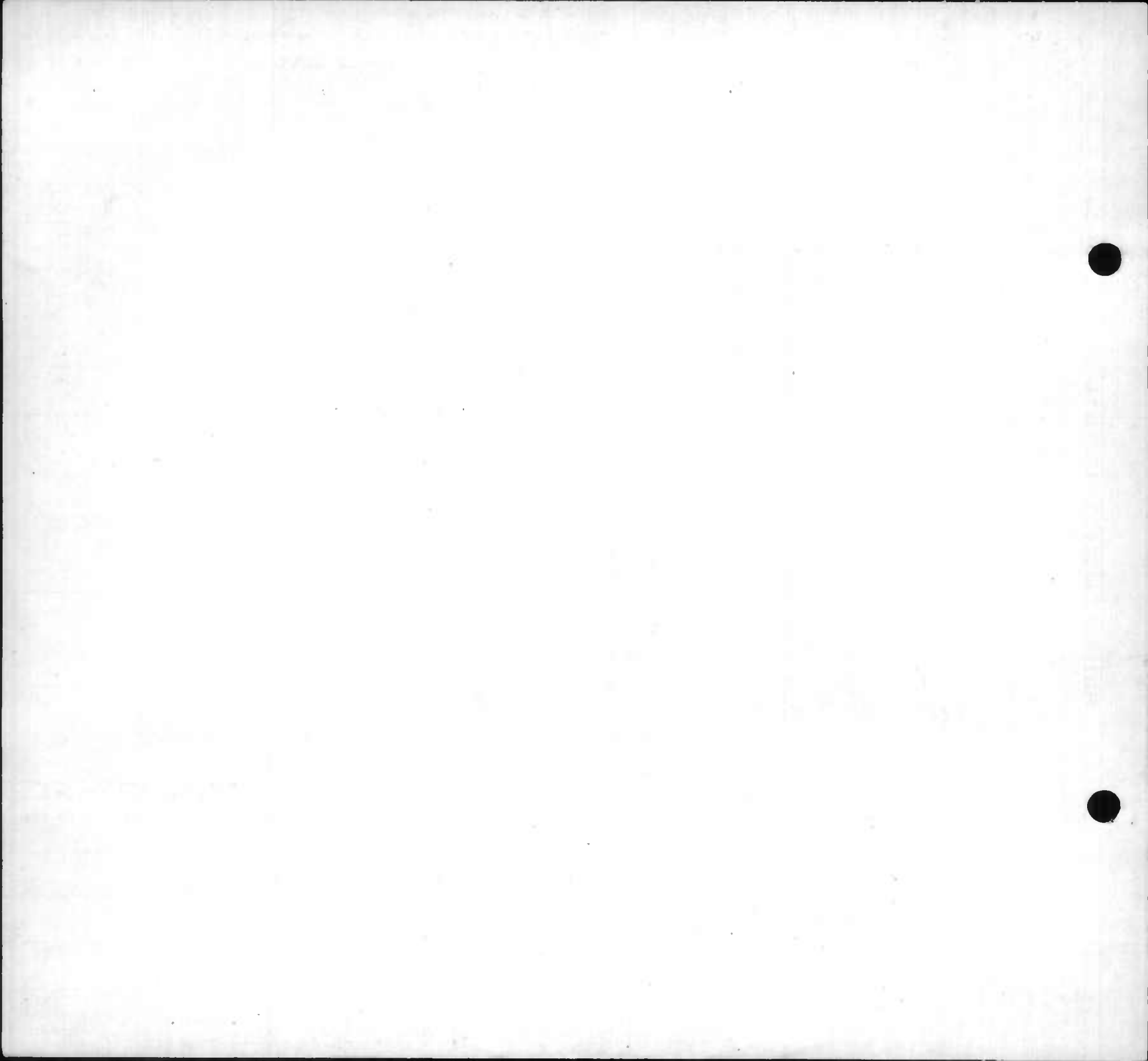




FUNERAL DIRECTOR: IMPORTANT

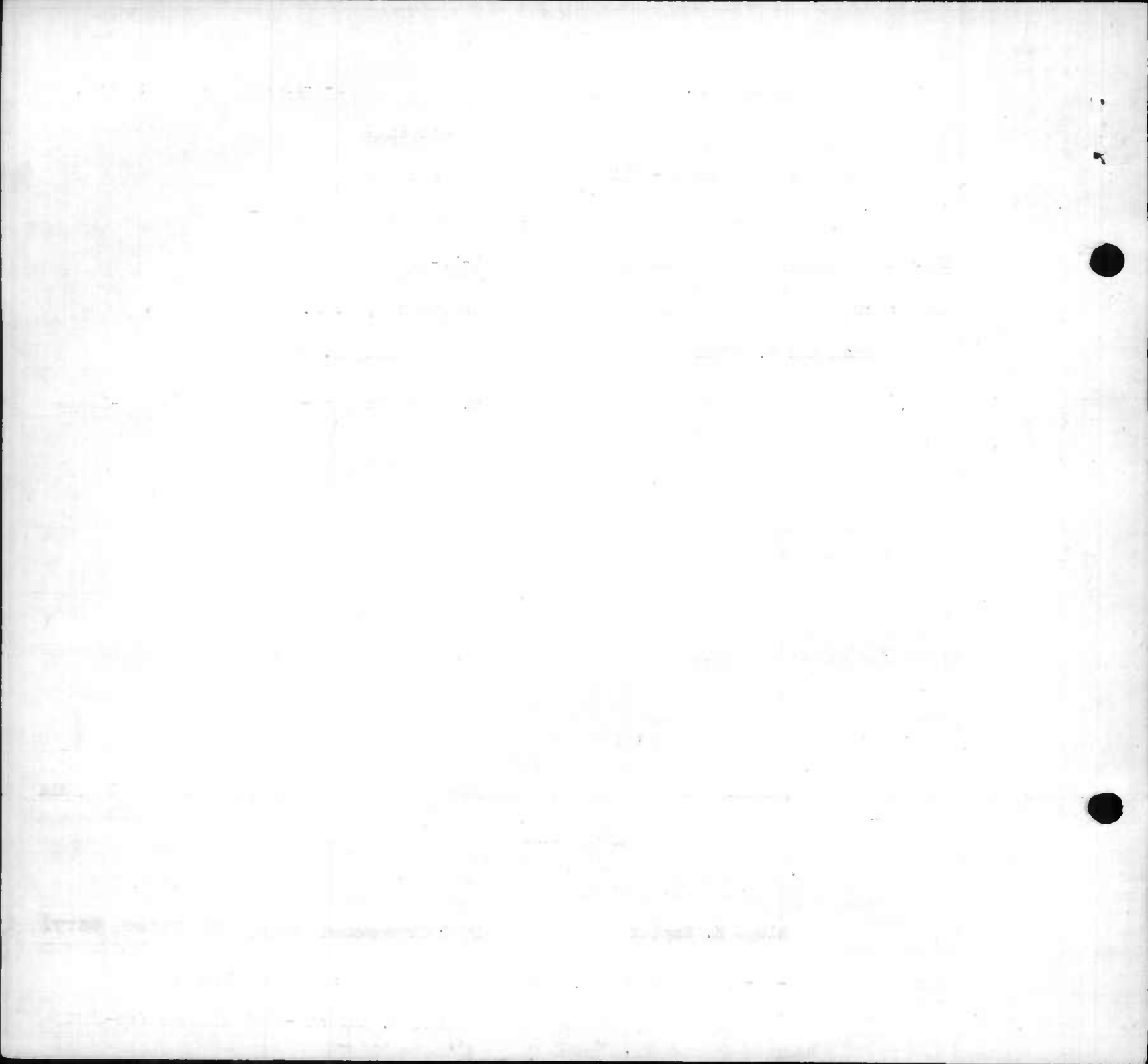
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

65 4913 BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4913	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print) VIRGINIA A. ( JENNIE ) FREDERICK			2. DATE AND HOUR OF DEATH MAY 7, 1965 3 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  1930 East 29th Street			A. STATE MARYLAND B. COUNTY 9-06		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218		
			D. STREET ADDRESS (If rural, give location) 1930 East 29th Street		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH Aug. 7, 1886	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Simon Blessing			14. MOTHER'S MAIDEN NAME Katherine Frostburg		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213003 3419 A		17. INFORMANT ADDRESS 1830 East 29th Street Mr. Walter H. Frederick	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) Arteriosclerotic cardiovascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 7 days Several years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 9 1963 to May 7 1965, that (I) <del>was</del> last saw the deceased alive on May 7 1965 and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.					
23A. SIGNATURE Seymour H. Rubin				23B. DATE SIGNED 5/8/65	
23C. PHYSICIAN'S NAME (Type) Seymour H. Rubin				23D. ADDRESS 3136 Harford Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 10, 1965		24C. NAME OF CEMETERY or CREMATORY Baltimore	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965			
25B. NAME OF REGISTRAR Robert E. Farber		25C. FUNERAL DIRECTOR ADDRESS Henry Sander & Sons Inc. Baltimore, Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4914	
BIRTH NO. 65 4914		CERTIFICATE OF DEATH		Registered No. 65 4914	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lillian A. Stanley		5-6-65 16:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
934 Argonne Drive - 21218		Maryland 9-01			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		934 Argonne Drive - 21218			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	Widow	2-27-73	92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Washington, D. C.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Franklin S. Ober			Mary A. French		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mr. Owen Earnshaw-934 Argonne Drive-21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			15 yrs.		
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from March 19 64 to May 6, 19 65, that (I) (we) last saw the deceased alive on April 26, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lloyd E. Saylor M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				May 7, 1965	
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Lloyd E. Saylor M.D.			3902 Greenmount Avenue Baltimore, Maryland		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5-10-65		Baltimore National	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1965		Robert E. Hubbard		Howard H. Hubbard-4107 Wilkens Ave-21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

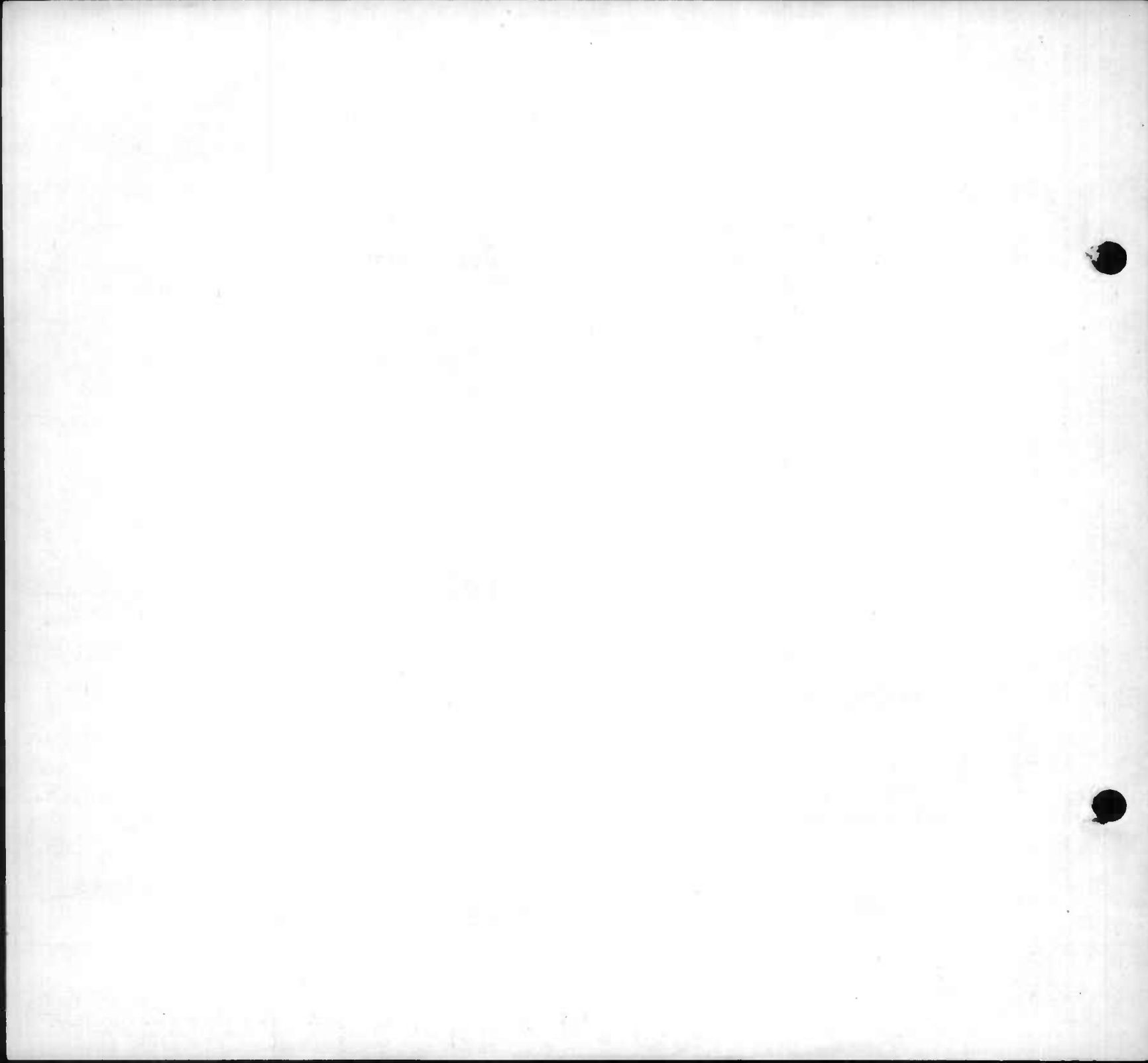
BIRTH NO. 65 4915		BALTIMORE CITY HEALTH DEPT.		Registered No. 65 4915	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Weber, William</b>			5/7/65 10:55 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>So. BALTO. Gen'l Hosp.</b> <b>1213 Light St. Baltimore 21230</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>23-02</b>		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21230</b>			D. STREET ADDRESS (If rural, give location) <b>1609 PATAPSCO ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>OCT 20 1891</b>	9. AGE (In years lost birthday) <b>73</b>	If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRYING OPERATOR (Ret.)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL-INSULATOR MFG.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>	
13. FATHER'S NAME <b>George Weber</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>01-1284</b>		17. INFORMANT ADDRESS <b>IRENE A. WEBER (Wife) Same</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>422.1 I</b> <b>Coronary Thrombosis Accident</b> <b>Anteroseptal Myocardial Infarction</b> <b>Disease.</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/7</b> 19 <b>65</b> to <b>5/7</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>5/7</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Douglas Weir</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/65</b>
23C. PHYSICIAN'S NAME (Type) <b>W. Douglas Weir</b>			23D. ADDRESS M.D. <b>1213 Light St. Baltimore Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>MAY 11 1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETARY</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD 65</b>		24E. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR ADDRESS <b>100-02 S. CHARLES STREET BALTIMORE, MD. 21230</b>	

157-0503  
BALTIMORE, MD. 21201  
1400 S. CHARLES STREET  
CURTIS E. EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <b>65 4916</b>	
BIRTH NO. <b>65 4916</b>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>ROGERS, MARY F.</b>			2. DATE AND HOUR OF DEATH <b>5/7-65. 2 PM. 2 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Lutheran Hospital of Md.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>15-02 Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2015 W. North Ave.</b>		
5. SEX <b>female</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 2, 1899</b>	9. AGE (In years last birthday) <b>65</b>	10. If Under 1 Yr. Months Days Hours Min. <b>15-02</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME <b>Annie Addison</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Charles E. Rogers</b> ADDRESS <b>1943 W. North Ave Baltimore Md. 21212</b>		
18. <b>434.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Congestive Heart failure</b> DUE TO <b>+ gangrene Right lower extremities. (Amputation)</b> (B) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>INTERVAL BETWEEN ONSET AND DEATH</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5/7/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/22/65</b> to <b>5/7/65</b> , that (I) (we) lost saw the deceased alive on <b>5/5 PM 5/7/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>S. Rajae</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>SAROOSH RAJAE</b>			23D. ADDRESS <b>Lutheran Hospital of Maryland.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-11-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fairbank</b>		25C. FUNERAL DIRECTOR <b>James H. Kuhn</b> ADDRESS <b>1348 N. Calhoun St.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4917</span>	
CERTIFICATE OF DEATH					
BIRTH NO. <span style="font-size: 1.2em;">65 4917</span>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ROLAND GARDNER</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 8 1965 9 55 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">UNIVERSITY HOSPITAL</span>			A. STATE <span style="font-size: 1.2em;">MD.</span> 8. COUNTY <span style="font-size: 1.2em;">27-10</span>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4404 ST GEORGE AVE</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">WIDOWED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/14/08</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Charles Gardner</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">EDNA</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">338-26-1331</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">HOSPITAL CHART</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.2em;">443X I</span> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Intracerebral hemorrhage</span> DUE TO (B) <span style="font-size: 1.2em;">Hypertensive cardiovascular disease</span> DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">unknown</span>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">5/8 9 30 am 19 65</span> to <span style="font-size: 1.2em;">5/8 9 55 am 19 65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/8 9 55 am 19 65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Herbert A. Kushner</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">5/8/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HERBERT A. KUSHNER</span>				23D. ADDRESS <span style="font-size: 1.2em;">University Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5-8-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Auburn Cem.</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 10 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">[Signature] 1370 N. Calhoun St</span>	

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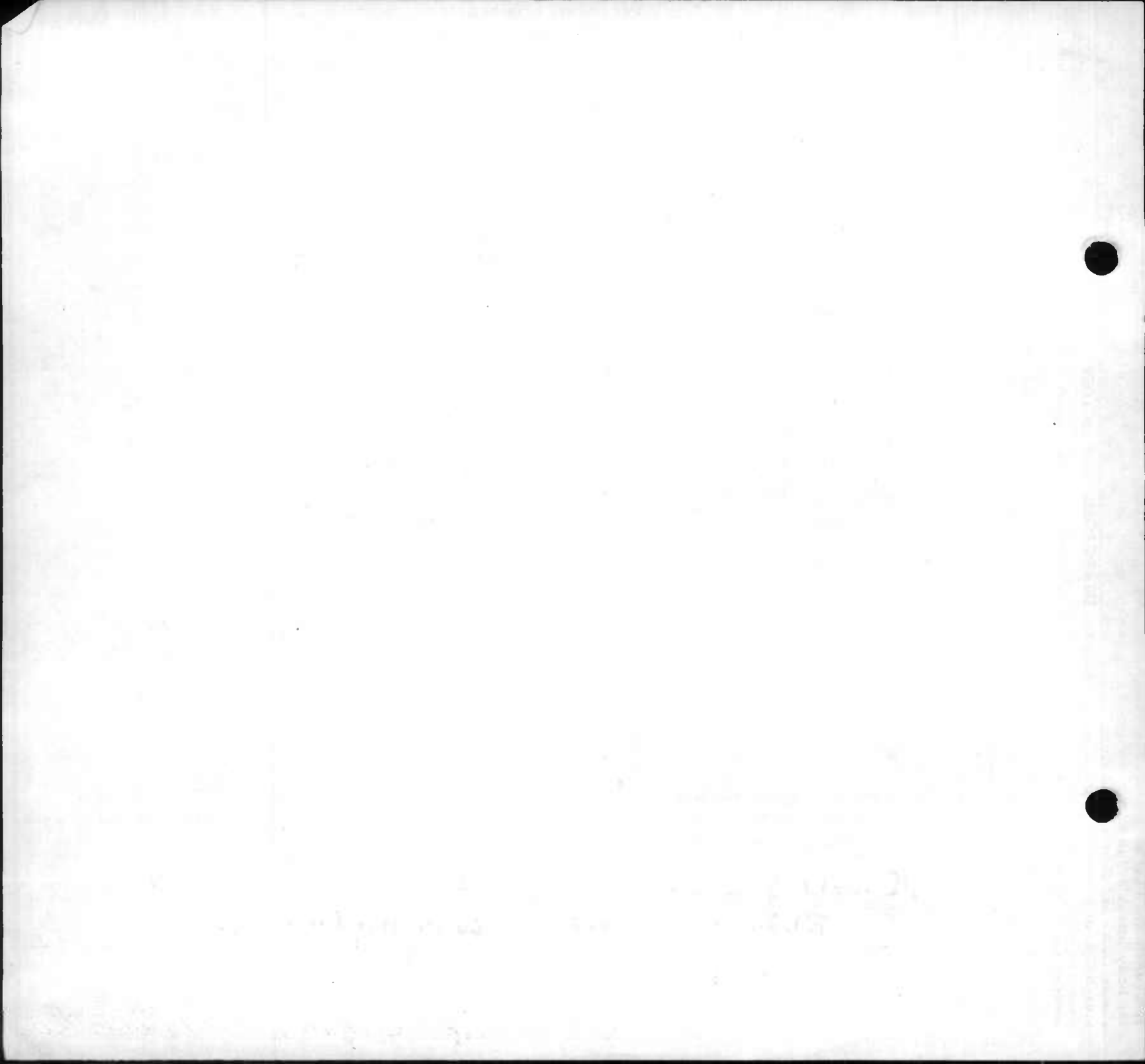
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 4918	
BIRTH NO. 65 4918				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Robert Lange			2. DATE AND HOUR OF DEATH 5-7-65 4. P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5904 Winthrop Ave			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-44 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5904 Winthrop Ave.		
5. SEX M.	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH Aug 31, 07	9. AGE (In years last birthday) 57	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER
11. BIRTHPLACE (State or foreign country) BALTO Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME H. Wm. LANCE			14. MOTHER'S MAIDEN NAME E. Ely Woferman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT WIFE ADDRESS SAME
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 260X I Generalized arteriosclerosis 2 years			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes mellitus 3 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic nephritis 10 years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RDonald Jandorf				23B. DATE SIGNED 5-7-65	
23C. PHYSICIAN'S NAME (Type) RDonald Jandorf				23D. ADDRESS 6077 Hartford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/65		24C. NAME OF CEMETERY OR CREMATORY IMMANUEL Cem.	
24D. LOCATION BALTO MD		24E. DATE REC'D BY HEALTH DEPT. MAY 10 1965		24F. NAME OF REGISTRAR R. E. F. Jandorf	
24G. FUNERAL DIRECTOR PA Heemann		24H. ADDRESS 6067 HARTF. RD			



1

65 4919

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4919

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES A. KELLY

2. DATE AND HOUR PRONOUNCED DEAD

May 8, 1965

2:09 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Pasadena

D. STREET ADDRESS (If rural, give location)

Box 163A, Route 7

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 23, 1921

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Public Relations

10B. KIND OF BUSINESS OR INDUSTRY

Kennecott Corp

11. BIRTHPLACE (State or foreign country)

N. Y.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James D. Kelly

14. MOTHER'S MAIDEN NAME

Irene Crowley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWII

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and Arteriosclerotic  
Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty

M.D.

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5/8/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-11-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Nat. Cem

23D. LOCATION

(City, town, or county)

Baltimore, MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 10 1965

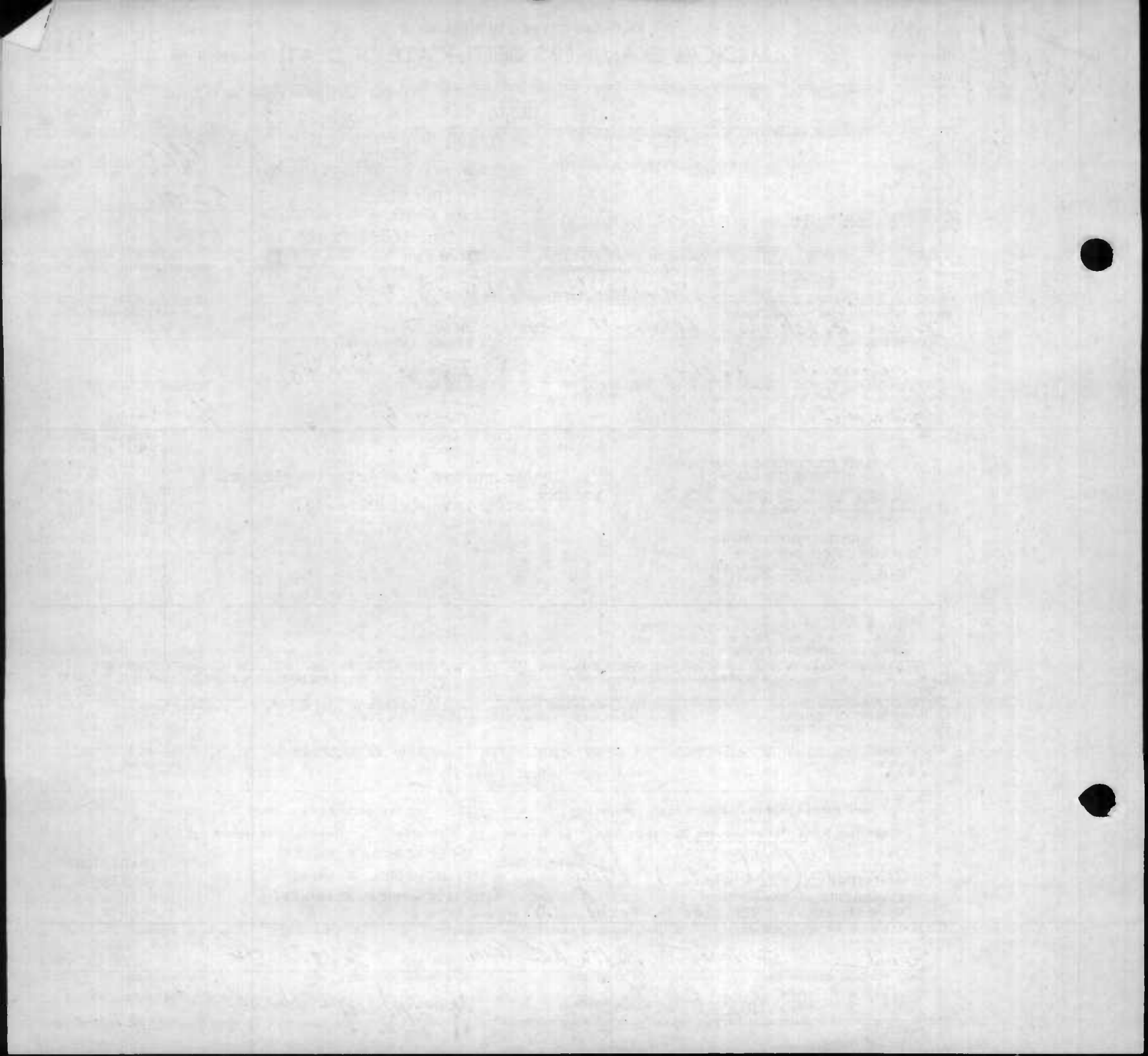
24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

McDuffy Funeral Home 237 Patuxent Ave

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4920		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4920	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Mrs. Tillie Carr				2. DATE AND HOUR OF DEATH 5-4-65 2:25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mountbello S. Hospital.				A. STATE Md. B. COUNTY Anne Arundel			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00			
				D. STREET ADDRESS (If rural, give location) 209 Harford Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 7-3-1872	9. AGE (In years last birthday) 92	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H-W.		10B. KIND OF BUSINESS OR INDUSTRY H.W.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Dilks				14. MOTHER'S MAIDEN NAME Charity Turner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mountbello S. Hospital.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last.				CAUSE OF DEATH (A) Arterio Sclerotic Cardiovascular Disease. (B) <del>Inter trochanteric fracture of left femur</del> (C) <del>Fracture</del>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Interval BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4-27-65				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Open reduction of H. hip		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) DONE				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME	
21D. TIME OF INJURY (APPROX.) 2-28-65				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? she fell in her way to the bathroom	
22. I certify that (I) (this hospital) attended the deceased from 5-3-1965 to 5-4-1965, that (I) (we) last saw the deceased alive on 5-4-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Orlando C. Ramos M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-4-65	
23C. PHYSICIAN'S NAME (Type) Orlando Ramos				23D. ADDRESS Mountbello S. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 7/65		24C. NAME OF CEMETERY or CREMATORY Northwood Cemetery		24D. LOCATION (City, town, or county) Germantown, Phila., Pa. (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965		25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR R. W. Singleton		ADDRESS Glen Burnie, Md.	



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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4921</u>	
BIRTH NO. <u>65 4921</u>				CERTIFICATE OF DEATH	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Green Stevenson</u>			3 - May - 65 10 45 P. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>			A. STATE <u>md</u> B. COUNTY <u>Balt</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore (Springfield St. Hosp.)</u>		
5. SEX <u>M</u> 6. RACE <u>W</u>			D. STREET ADDRESS (If rural, give location) <u>127 East North Ave</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Wid.</u>			8. DATE OF BIRTH <u>?</u> 9. AGE (In years last birthday) <u>78</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Coppersmith</u>			11. BIRTHPLACE (State or foreign country) <u>Russia</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Steve Stevenson</u>			14. MOTHER'S MAIDEN NAME <u>UNK</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>Hospt. Rec.</u>		
18. <u>561.51</u>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) <u>Acute Gastric Dilatation</u> 24 h.		
			(B) <u>S.B. obstruction</u>		
			(C) <u>Incarcerated Hernia</u>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>3-may</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Emergency</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>1-may</u> 19 <u>65</u> to <u>3 may</u> 19 <u>65</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>3 may</u> 19 <u>65</u> and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>we</u> ) ( <u>did</u> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>J. Marcel</u>				23B. DATE SIGNED <u>3-may 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>J. Marcel</u>				23D. ADDRESS <u>90 UH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>MAY 7, 1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Tampa Florida</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			
25B. NAME OF REGISTRAR <u>John E. Feltner</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Gannon</u>			
25D. ADDRESS <u>263 S. Conkhing St.</u>					

University Hospital

M W

State 21st Division

23 September  
Incorporated 1923

3-10-23

Brooklyn

10

*[Signature]*  
10/10/23

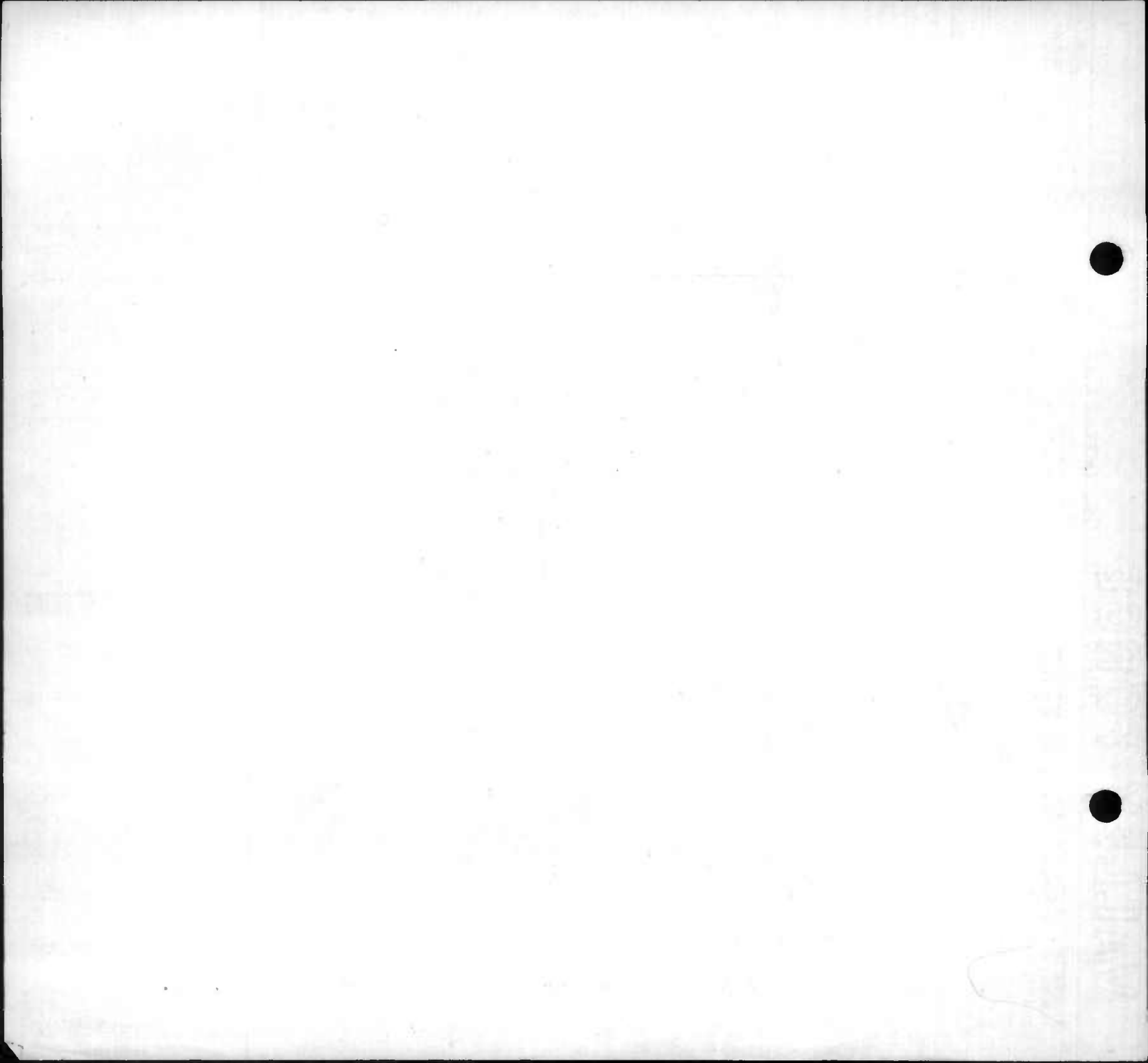
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RELEASED BY MEDICAL EXAMINER WITH NO CONDITIONS 5-3-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and 60 days prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 262 65 4922		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4922	
BIRTH NO. 65 4922					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>ROGERS</b>			2. DATE AND HOUR OF DEATH <b>5-3-65 6 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>The Union Memorial Hosp</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-05</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 11.</b> D. STREET ADDRESS (If rural, give location) <b>2954 KESWICK RD.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>widowed</b>	8. DATE OF BIRTH <b>12/17/1892</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>
13. FATHER'S NAME <b>George Brinton Schuim Key</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Shutz</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT <b>Goldie Yost</b>		ADDRESS <b>433-7995.</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute peritonitis perforated gastric ulcer leading to lacerated duodenum</b>			CAUSE OF DEATH <b>Acute peritonitis perforated gastric ulcer leading to lacerated duodenum</b>		INTERVAL BETWEEN ONSET AND DEATH <b>ARD</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>RELEASED BODY UNCONDITIONAL</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg.) <b>-</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>		
21D. TIME OF INJURY (APPROX.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>-</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> 19 <b>65</b> to <b>5-3</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5-3-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen Kopits,</b>			23B. DATE SIGNED <b>5-3-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Stephen Kopits,</b>			23D. ADDRESS <b>The Union Memorial Hosp.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>5/6/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Frederick Rd, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Feltz, M.D.</b>	25C. FUNERAL DIRECTOR <b>Augustine Brown - 3818 Blount Ave</b>			



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65 4923

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 4923

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

OWEN MC ATTER

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1965

9:50 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

S. Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

808 Jack St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 26, 1890 74

9. AGE (In years  
last birthday)

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Railroad shops

10B. KIND OF BUSINESS OR INDUSTRY

B & O

11. BIRTHPLACE (State or foreign country)

Frostburg, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James McAteer

14. MOTHER'S MAIDEN NAME

Mary Tippen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

705-12-4215

17. INFORMANT

ADDRESS

Mrs. Owen McAteer, 808 Jack St., Balt. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
m. WORK AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED  
5-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 8, 1965

23C. NAME of CEMETERY or CREMATORY

St. Michael's Cemetery Frostburg

23D. LOCATION

(City, town, or county)

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAY 10 1965

24B. NAME OF REGISTRAR

Philip E. Fairman

24C. FUNERAL DIRECTOR

HAFFER FUNERAL HOME, 60 West Main St,  
Frostburg, Md. Marilee M. Sowers

WILLER BOBGE

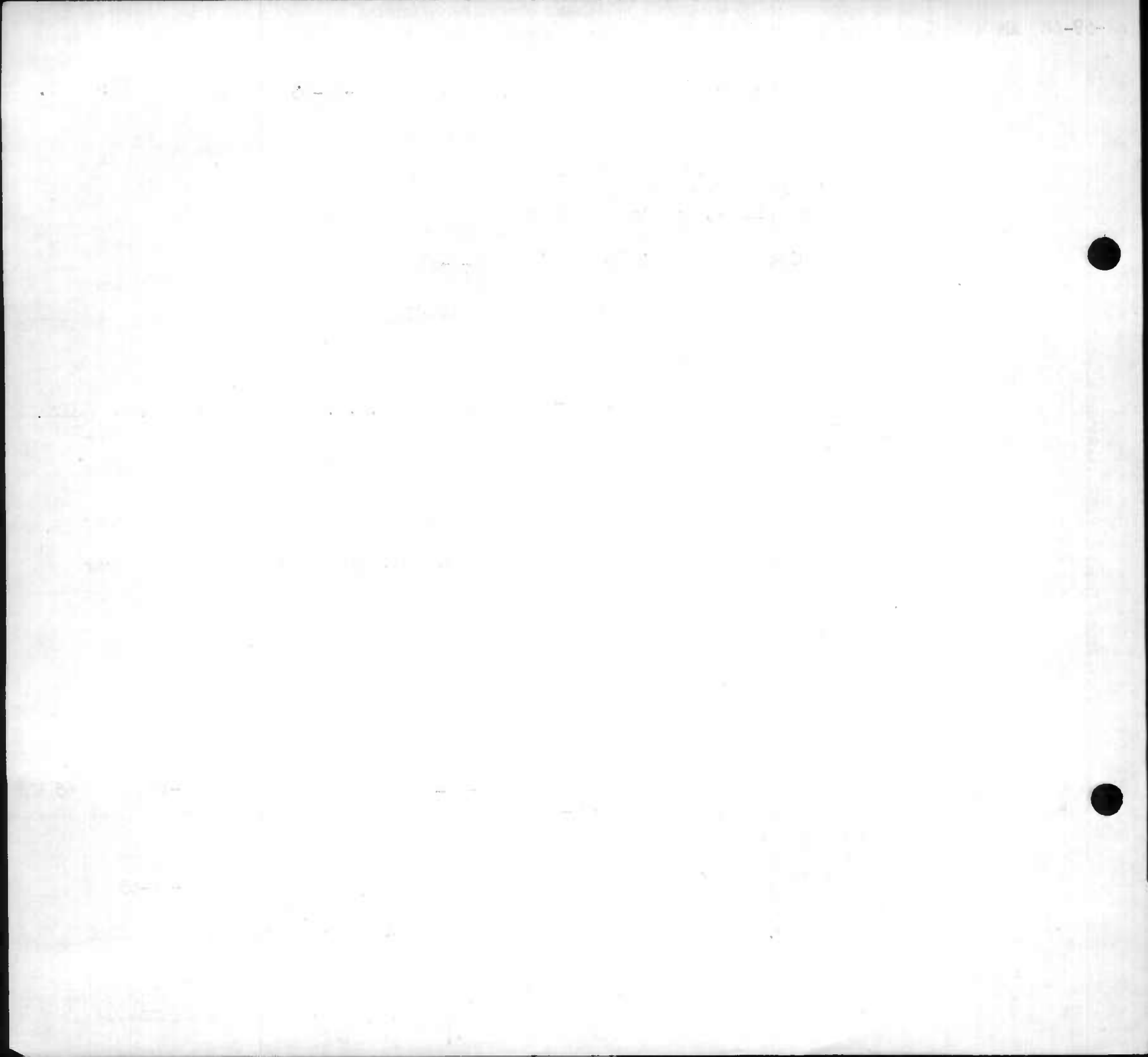
THIS CONTENT

42-59-48 AM 1

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D110 65 4924		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4924	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Tony Di Piava		4-28-65		11:00 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		Maryland		4-01	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		48 Market Place			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days Hours Min.
Male	White	Single	1-1-91	74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Italy	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Di Piava					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		219-03-8294		RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) Squamous Cell Carcinoma Face		1 Year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Carcinomatosis		1 Year	
		(C) Benign Prostatic Hypertrophy		1 Year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-12-19 65 to 4-28-19 65, that (I) (we) last saw the deceased alive on 4-28-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Dr. Charles Carpenter				4-28-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. Charles Carpenter		4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5/10/65		Sacred Heart	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1965		Robert E. Johnson		William J. Dickner & Sons North & Anna Dickner	

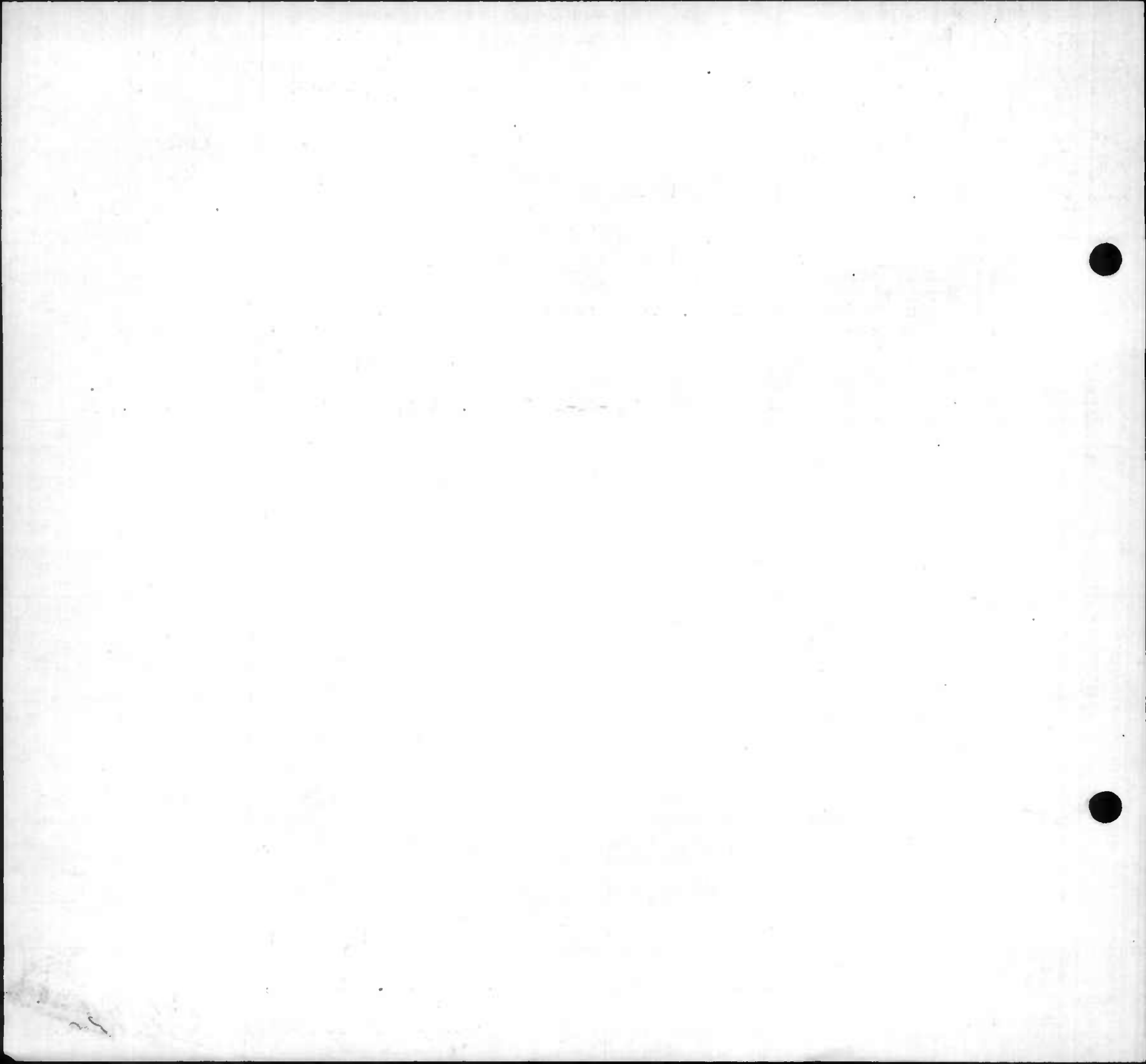




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 4925</u>				
BIRTH NO. <u>65 4925</u>									
M.E. CASE NO. <u>65 4925</u>									
1. NAME OF DECEASED (Type or Print) <u>HARRY ECKMAN</u>					2. DATE AND HOUR OF DEATH <u>5-7-65</u> <u>6.30</u> <u>A</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> If not in hospital or institution, give street address or location					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balt</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1842 EDGEWOOD RD.</u> <u>34</u>				
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED <u>WIDOWER</u>	8. DATE OF BIRTH <u>10-22-82</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work or business most of working life, even if retired) <u>Man Retired Petrol Corp. City Service</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>CORP. City Service</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HARRY ECKMAN</u>					14. MOTHER'S MAIDEN NAME <u>MARY CATHERINE WOODALL</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>			16. SOCIAL SECURITY NO. <u>214-01-1552</u>		17. INFORMANT <u>Mr. William Barnhard</u> <u>1842 Edgewood Rd.</u> <u>Baltimore, Md.</u> <u>34</u>				
18. <u>473X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
19A. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initally medical examined)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> <u>1965</u> to <u>5-7</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>5-7</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Antonio Dalmerico</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANTONIO DALMERICO</u> M.D.					23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park Cemt.</u>			24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fagan</u>			25C. FUNERAL DIRECTOR <u>Wm. J. Fickner &amp; Sons</u> <u>Baltimore, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4926 CERTIFICATE OF DEATH					Registered No. 65 4926				
BIRTH NO. 65 4926					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <b>ROBERT Vance CARTER</b>					2. DATE AND HOUR OF DEATH <b>5/8/65 12<sup>10</sup> A</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALT</b>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 27-16</b>				
					D. STREET ADDRESS (If rural, give location) <b>3107 WOODLAWN AVE 15</b>				
5. SEX <b>M</b>	6. RACE <b>CAUC</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12/26/11</b>	9. AGE (in years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pump Operator BFD</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Fire Department</b>		11. BIRTHPLACE (State or foreign country) <b>BALT MD</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas V. Carter</b>					14. MOTHER'S MAIDEN NAME <b>Sara Louise Huber</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>3107 Woodlawn Ave. Mrs. Christine Carter Baltimore, Md. 15</b>				
18. CAUSE OF DEATH <b>199-2-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>MESOTHELIOMA OF PLEURA AND PERICARDIUM WITH METASTASES</b>					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>4/5</b> 19 <b>65</b> to <b>5/8</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/8</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Henry A. Jovin</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>5/8/65</b>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/12/1965</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>			25B. NAME OF REGISTRAR <b>Robert S. Feltman</b>			25C. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Feltman &amp; Son 21217 North Ave.</b>			

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4927	
BIRTH NO. 65 4927		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Miss Eva Weiss		2. DATE AND HOUR OF DEATH 5/9/65 11:45 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) The Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6/10/1889	
13. FATHER'S NAME Jacob Weiss		14. MOTHER'S MAIDEN NAME Virginia F. Block		9. AGE (In years last birthday) 75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-0397		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Miss Rosa Weiss		ADDRESS 2525 Eutaw Place		12. CITIZEN OF WHAT COUNTRY? USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/7 1965 to 5/9 1965, that (we) last saw the deceased alive on 5/9 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		23A. SIGNATURE William B. Long		23B. DATE SIGNED 5/9/65	
23C. PHYSICIAN'S NAME (Type) William B. Long		23D. ADDRESS		23E. DATE SIGNED	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/1965		24C. NAME of CEMETERY or CREMATORY Hebrew Friendship Cemetery	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. MAY 10 1965		24F. NAME OF REGISTRAR Robert E. Feltner	
24G. DATE REC'D BY HEALTH DEPT. MAY 10 1965		24H. NAME OF REGISTRAR Robert E. Feltner		24I. FUNERAL DIRECTOR Wm. A. Dickson + Sons North Pa. Ave.	

V.S. 153

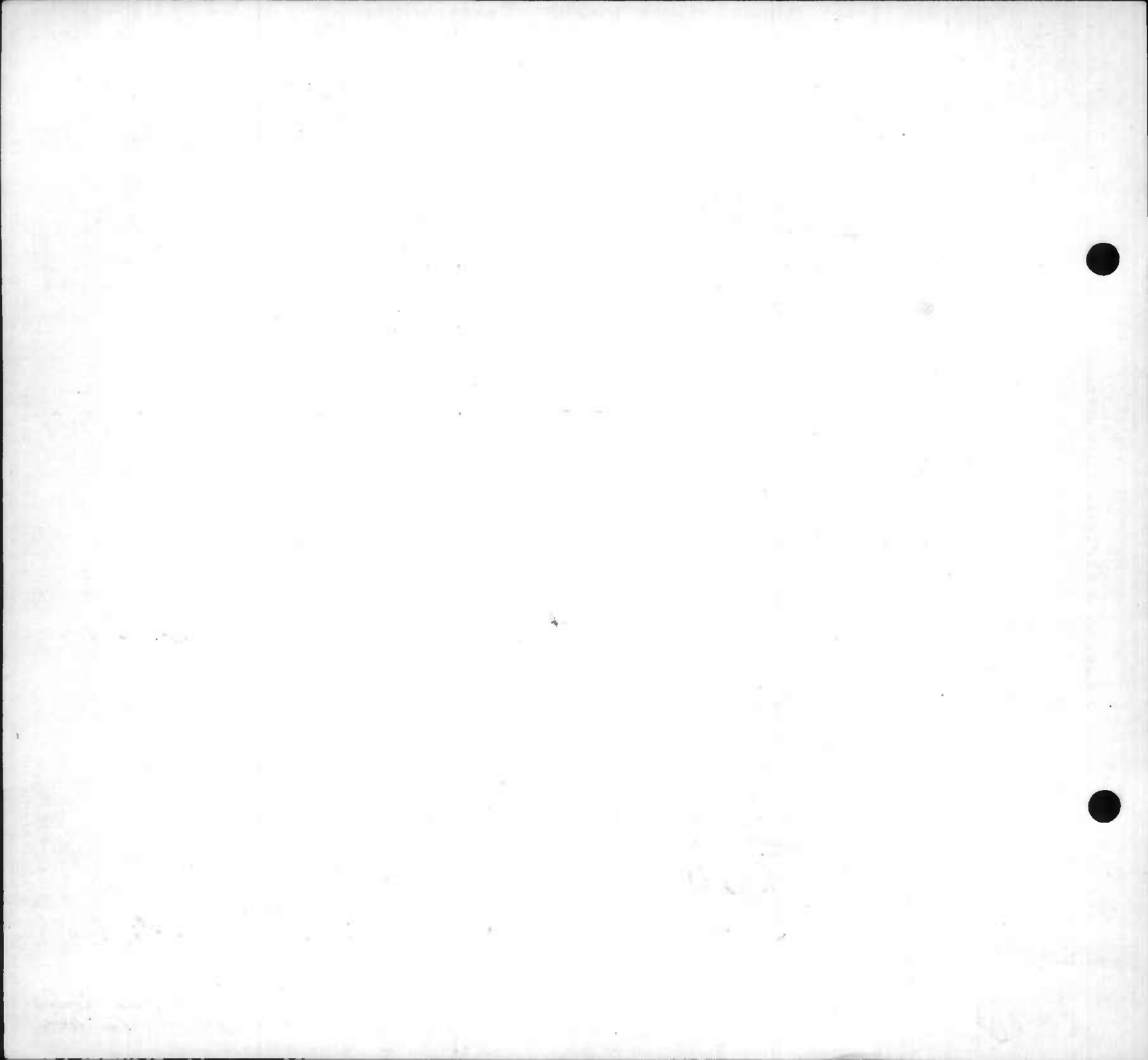
5-10-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. 65 4928</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>Registered No. 65 4928</p>	
<p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>Olive Ray</b></p>		<p>2. DATE AND HOUR OF DEATH <b>May 7, 1965</b></p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Fayette Convalescent Home</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5-01</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>1105 East Fayette Street 21202</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b></p>	<p>8. DATE OF BIRTH <b>Aug. 2, 1881</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) <b>83</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME <b>Lorenze Don Bond</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Catherine Mattingly</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <b>577-10-2886A</b></p>	<p>17. INFORMANT <b>Mr. Thomas Grogan</b></p>
		<p>ADDRESS <b>929 North Howard St. Baltimore, Md. 21201</b></p>	
<p>18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Branchopneumonia</b></p>		<p>CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO</p>	
<p>INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b></p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASG 100</b></p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Several yrs</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>J. Hulla</b></p>		<p>23B. DATE SIGNED <b>7 May 65</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>J. Hulla</b></p>		<p>23D. ADDRESS M.D. <b>2214 E Fayette St 21231 Balt Md</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>	<p>24B. DATE <b>5/10/1965</b></p>	<p>24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Sutland, Maryland</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Wm. J. Dupont &amp; Sons</b></p>		<p>ADDRESS <b>Balto, Md. 21217</b></p>	

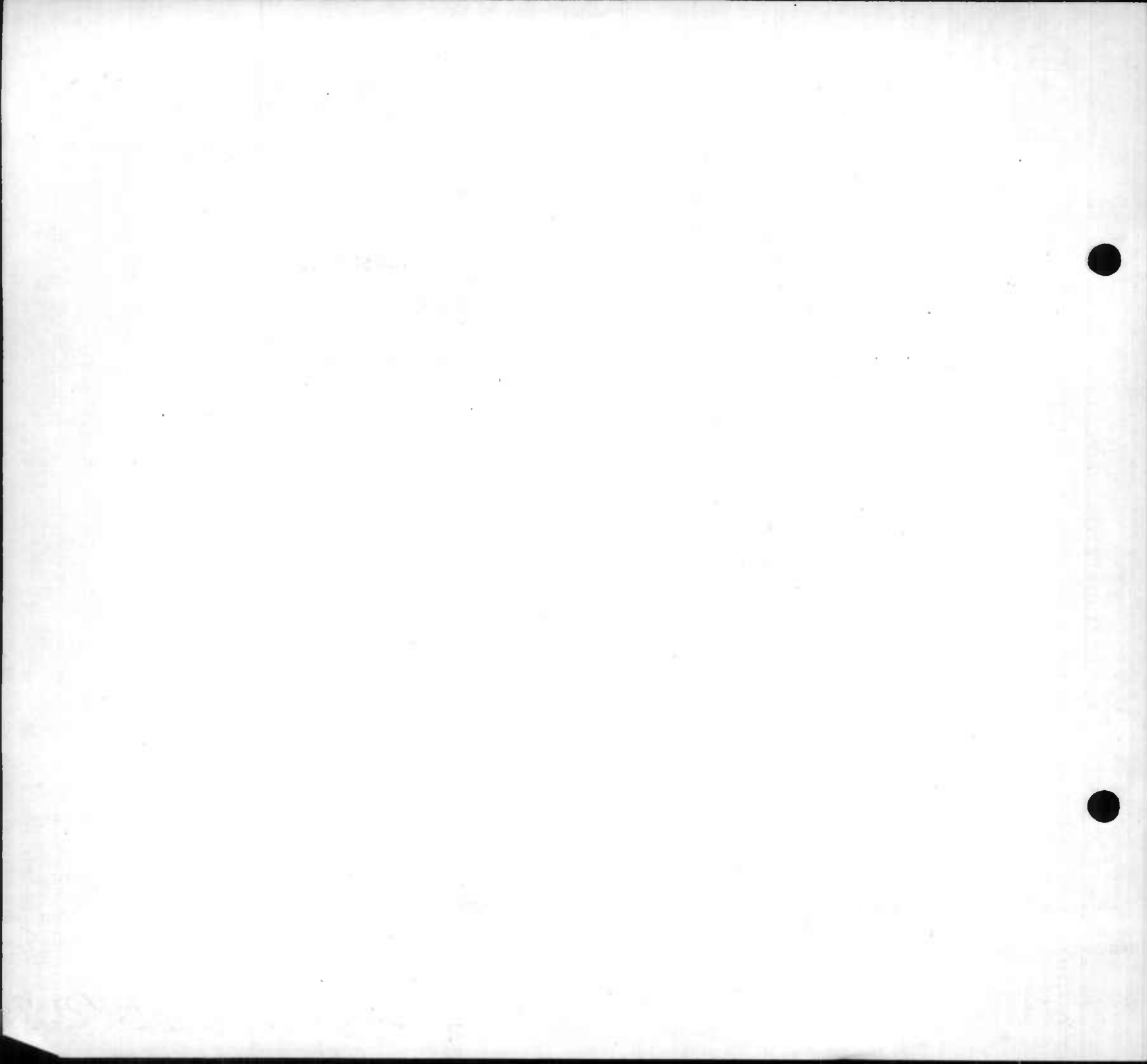




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4929</u>	
BIRTH NO. <u>65 4929</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>May 7, 1965</u> <u>8 A</u> M.			
1. NAME OF DECEASED (Type or Print) <u>Kathleen Darrin</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-14</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4401 Wickford Road Baltimore, Maryland 21210</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>4401 Wickford Road 21210</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>March 26, 1892</u>	9. AGE (In years last birthday) <u>73</u>	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wyoming</u>	
13. FATHER'S NAME <u>A. M. Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Catherine White</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Marc Darrin 4401 Wickford Road Baltimore, Md. 21210</u>	
18. <u>4201 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>5-20</u> 19 <u>59</u> to <u>5-7</u> 19 <u>65</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>5-1</u> 19 <u>65</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>Alfred G. Ossman Jr.</u>				23B. DATE SIGNED <u>5-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alfred G. Ossman Jr.</u>				23D. ADDRESS <u>1010 St Paul St Baltor Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/10/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikeville, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fidler</u>		25C. FUNERAL DIRECTOR <u>Wm. L. Dickman &amp; Sons</u>			
25D. ADDRESS <u>Balt, Md. 21217</u>		25E. ADDRESS <u>North Pa. Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T600 1		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4930	
BIRTH NO. 65 4930		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Russell W. Tower		2. DATE AND HOUR OF DEATH 5-8-65 4:45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. STREET ADDRESS Blackstone Apts. 3215 North Charles St.			
5. SEX Male		6. RACE Cauc.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 5-4-94		9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) V.P. Cumberland Coal Co. Coal	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME EDWARD Tower		14. MOTHER'S MAIDEN NAME Sarah Vaughn			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Suzanne Tower	
18. 422.11		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Congestive Heart Failure 5 weeks			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) A. S. C. V. D. with cardiac			
ANTECEDENT CAUSES		(C) pacemaker.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary Emphysema			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-11-1965 to 5-8-1965, that (I) (we) lost saw the deceased alive on 5-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodney L. Brimhall M.D.				23B. DATE SIGNED 5-8-65	
23C. PHYSICIAN'S NAME (Type) RODNEY L. BRIMHALL				23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAY 10 1965			
24F. NAME OF REGISTRAR Robert E. Finkbeiner		24G. FUNERAL DIRECTOR Wm. J. Finkbeiner			
24H. ADDRESS 21217		24I. ADDRESS 21217			

JOHN L. SMALL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

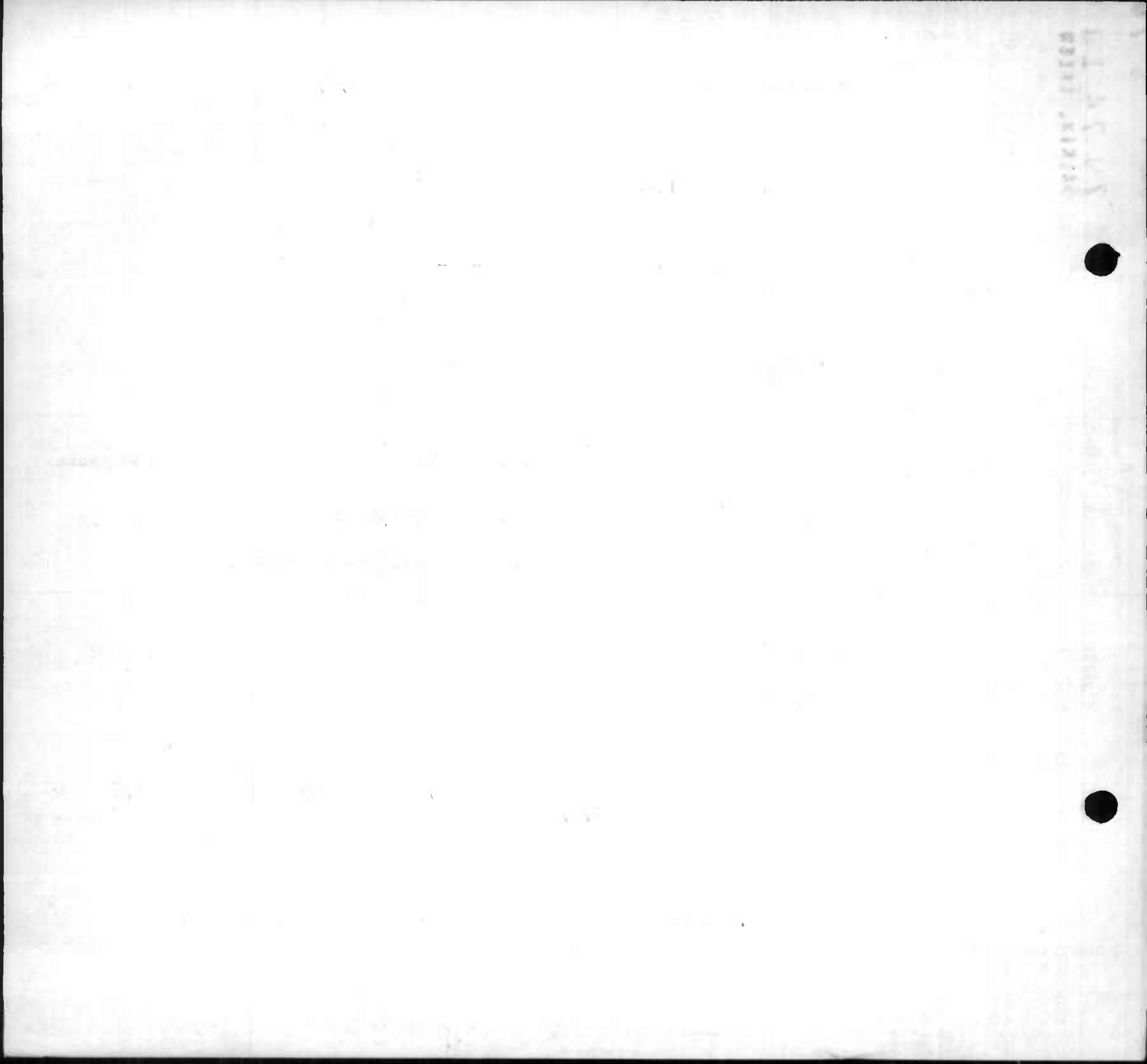
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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. **65 4931**

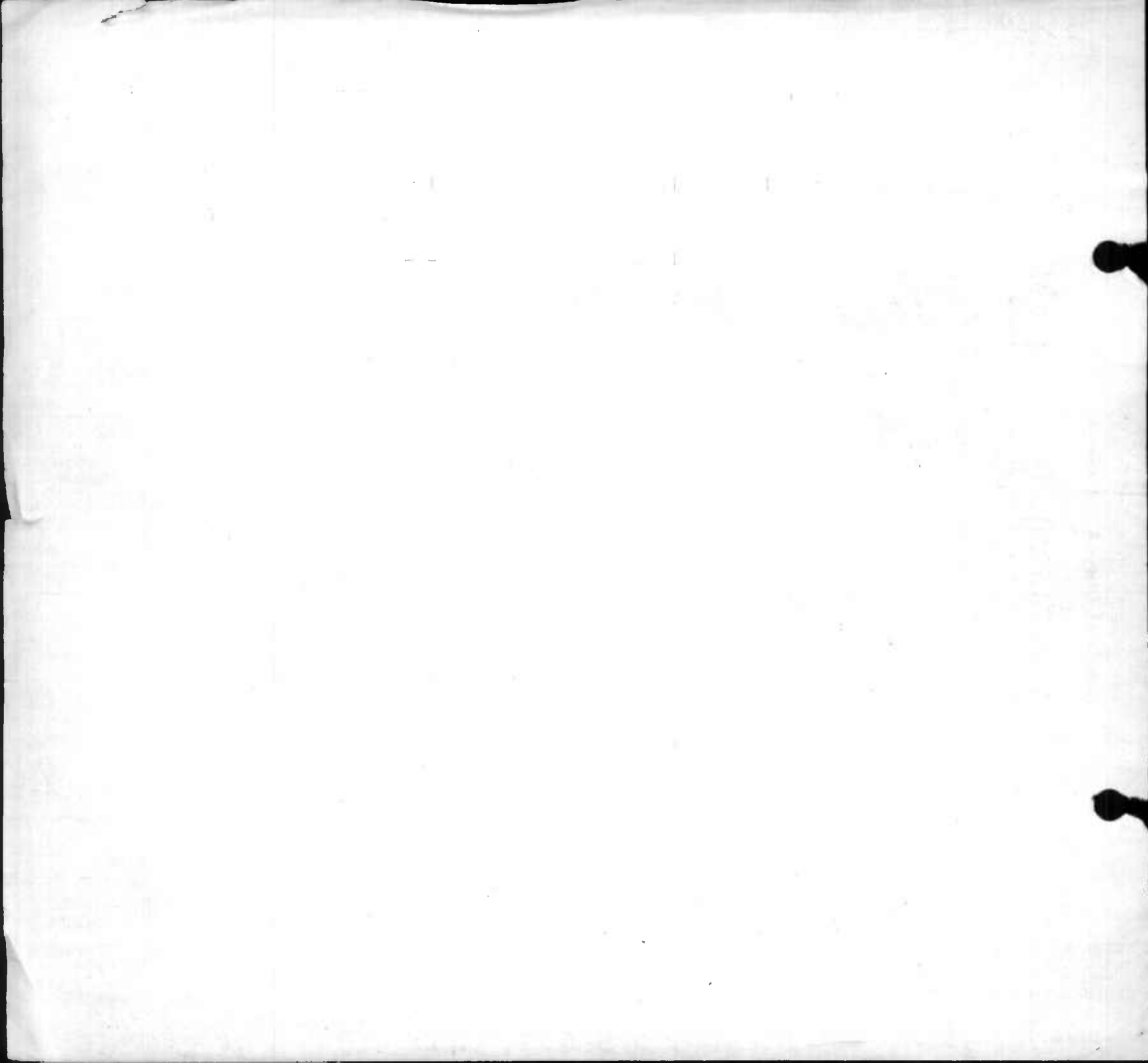
BIRTH NO. <b>65 4931</b>		M.E. CASE NO. <b>65 4931</b>	
1. NAME OF DECEASED (Type or Print) <b>Ereen BASKIN E.</b>		2. DATE AND HOUR OF DEATH <b>5/7/65</b> <b>7</b> <b>A.</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>3-201</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>268 HERRING COURT</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>3-29-85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>80</b>
11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WADE COFIELD</b>		14. MOTHER'S MAIDEN NAME <b>EMMA SAUNDERS</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-20-0175A</b>	
17. INFORMANT <b>ETHEL GORDON</b>		ADDRESS <b>115 E. MONUMENT ST</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>ASCVD CVA</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiac arrhythmia</b> <b>4 days</b> <b>ASCVD ? digitoxin toxicity</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>65</b> to <b>5/7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>5/7/</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Gino V. Segre</b>		23B. DATE SIGNED <b>5/7/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Gino V. Segre</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5-11-65</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT. AUBURN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>JOSEPH KNIGHT</b>	
25C. FUNERAL DIRECTOR <b>JOSEPH KNIGHT</b>		ADDRESS <b>1639 N. BROADWAY</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 4932</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 4932</b>	
1. NAME OF DECEASED (Type or Print) <b>SIMMS, JAMES</b>			2. DATE AND HOUR OF DEATH <b>5-7-65 6:20AM</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>8-04</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2203 EAST BRESTON STREET</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>1 1-8-11</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>POTOMAC COAL CO</b>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>JOHN SIMMS</b>			14. MOTHER'S MAIDEN NAME <b>ESTELLE Dorsey</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Carlinoma of Hypopharynx</b> <b>C multiple metastasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>April 1964</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>4/21/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Paraplegia due to metastasis</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/21 1965</b> to <b>5/7/1965</b> , that (I) (we) last saw the deceased alive on <b>5/7 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (and) (not) view the body after death.					
23A. SIGNATURE <b>K. Ambrosini</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5/7/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>KAZEM - ABBASSIDUN</b>			23D. ADDRESS <b>Johns Hopkins Hosp. Baltimore 5, Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>5/11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph J. Beck, Jr. 1304 N Central</b>	

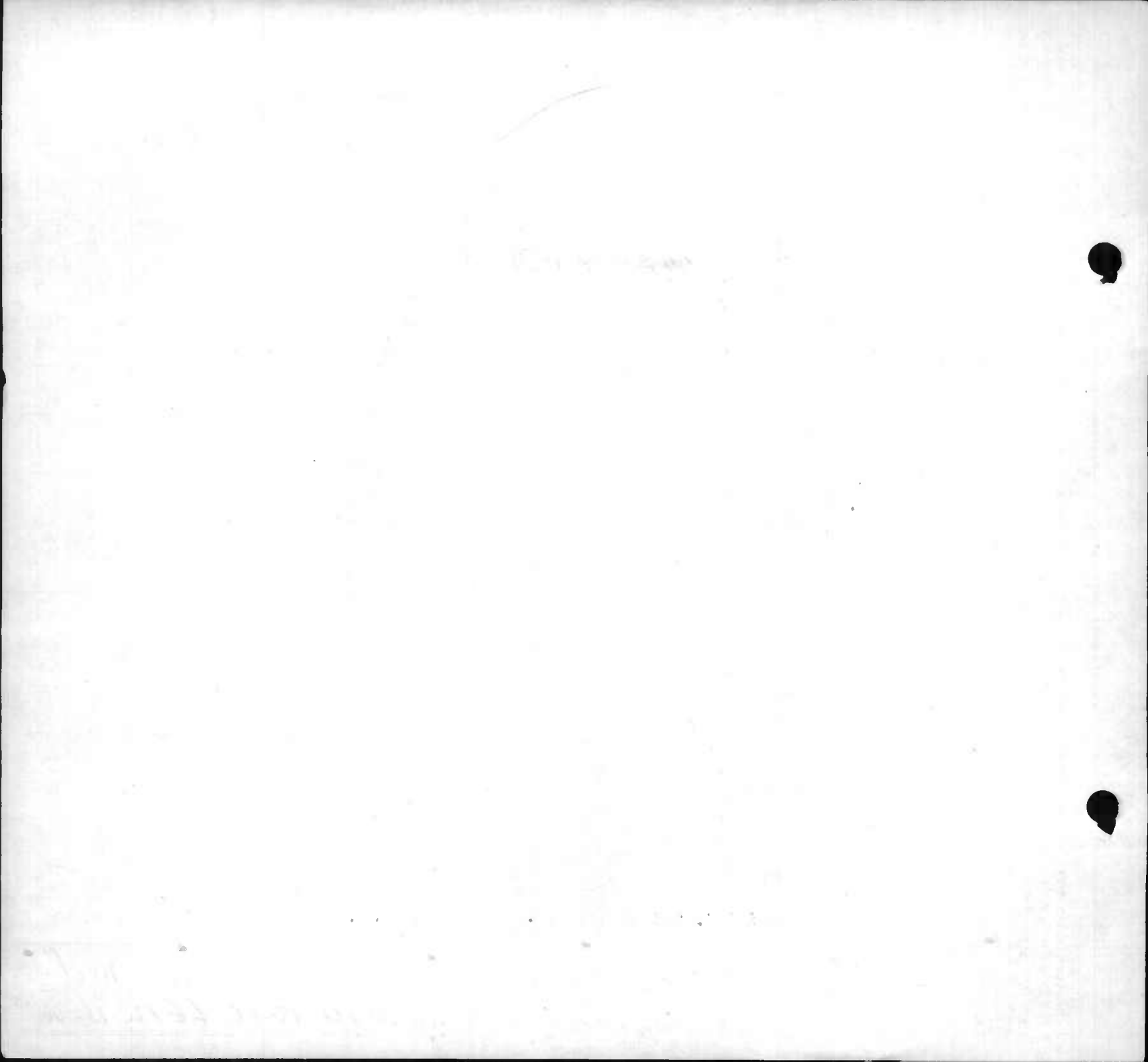




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		65 4933	
BIRTH NO. 65 4933		CERTIFICATE OF DEATH	
M.E. CASE NO.		Registered No. 65 4933	
1. NAME OF DECEASED (Type or Print) <i>Clifton, Dorsey E.</i>		2. DATE AND HOUR OF DEATH <i>5/8/65 3:30 AM</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hosp.</i>		A. STATE <i>MD.</i> B. COUNTY <i>21-01</i>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>	
		D. STREET ADDRESS (If rural, give location) <i>314 Otterbein Street</i>	
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>12/18/20</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>44</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Harold Dorsey</i>		14. MOTHER'S MAIDEN NAME <i>Anna Brooks</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>99-14-9773</i>	17. INFORMANT ADDRESS <i>Viola Palmer 314 Otterbein</i>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>15 7X1</i>		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <i>cardiac arrest</i> DUE TO (B) <i>cachexia</i> DUE TO (C) <i>carcinoma, pancreas</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>9 mo.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>4 May 1965</i> to <i>8 May 1965</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>8 May 1965</i> and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> <i>(did)</i> (did not) view the body after death.			
23A. SIGNATURE <i>Robert W. Ireland</i>		23B. DATE SIGNED <i>5/8/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Robert W. Ireland, M.D.</i>		23D. ADDRESS <i>Montebello State Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/12/65</i>	
24C. NAME of CEMETERY or CREMATORY <i>Baltimore National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Ireland</i>	
25C. FUNERAL DIRECTOR <i>Charles A. Rice</i>		ADDRESS <i>661 W. Barre St</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

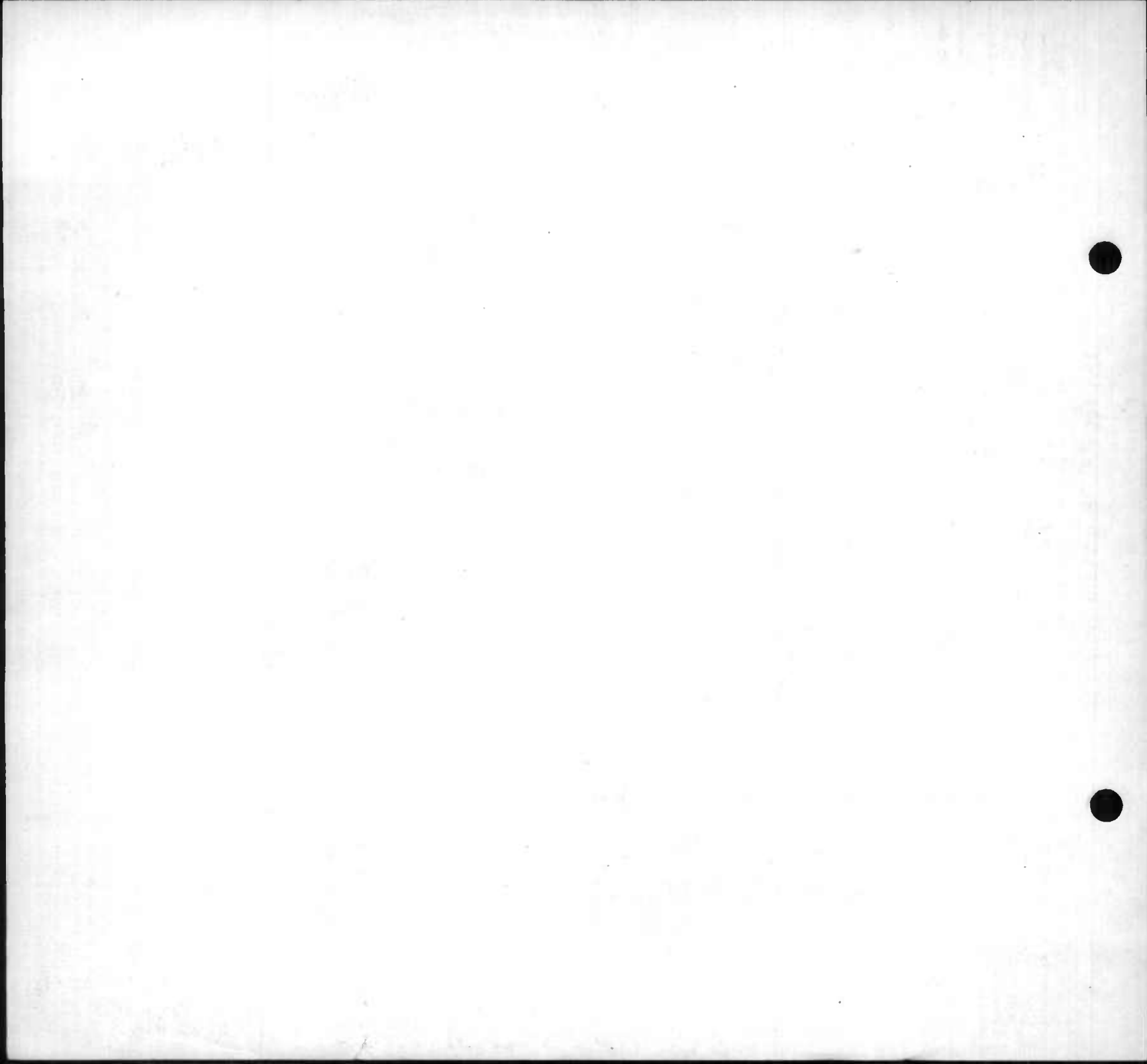
BIRTH NO.		65 4934		CERTIFICATE OF DEATH		Registered No. 65 4934	
1. NAME OF DECEASED (Type or Print) <u>Wilson Reller Rutherford</u>				2. DATE AND HOUR OF DEATH <u>May 7, 1965 9:30 P</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>				A. STATE <u>Maryland</u> B. COUNTY <u>27-02</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, Md.</u>			
				D. STREET ADDRESS (If rural, give location) <u>4510 Weitzel Ave</u>			
5. SEX <u>M</u>	6. RACE <u>Cauc</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>7-7-1890</u>	9. AGE (In years lost birthday) <u>74</u>	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Radiator repair</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Martin Luther Rutherford</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Faust FAUGHT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>217-039412</u>		17. INFORMANT <u>old chart</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>330X1</u>				CAUSE OF DEATH <u>Subarachnoid hemorrhage massive of both hemispheres</u>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <u>Arteriosclerosis of cerebral arteries</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>5-3-65</u> to <u>5-7-65</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>5-7-65</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <u>Charles T. Fletcher</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>May 7, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>CHARLES T. FLETCHER</u>				23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>May 11, 1965</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Wm Cook Brooks Tauson</u>		ADDRESS <u>1050 YORK RD Tauson MD 21204</u>	

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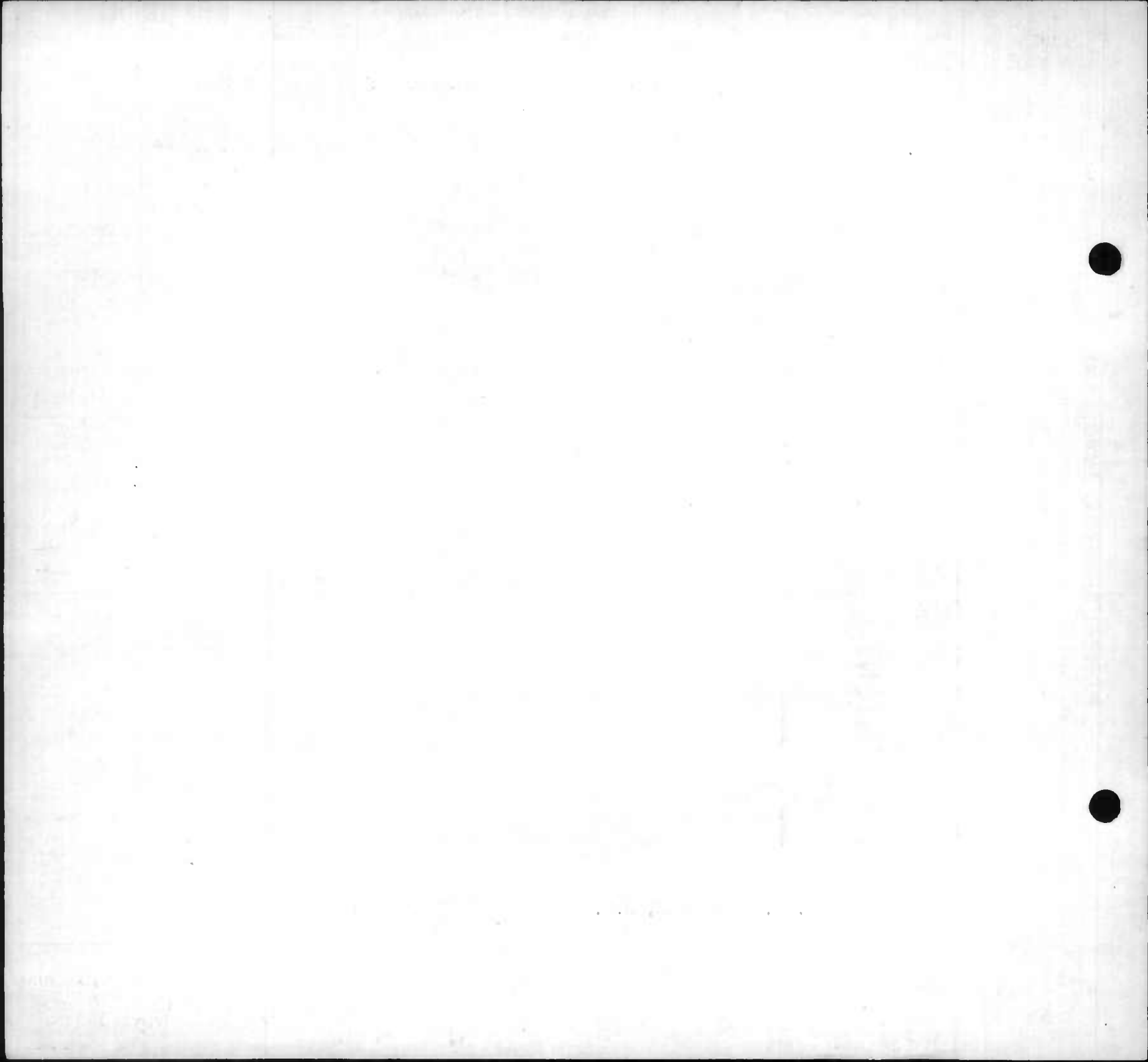
# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 65 4935					CERTIFICATE OF DEATH					Registered No. 65 4935						
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Mr Edward Bohn Iofink					2. DATE AND HOUR OF DEATH May 6-65-1 19:40 H M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-38					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp. Baltimore Md					D. STREET ADDRESS (If rural, give location) 6103 Marlboro Road											
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Aug 18, 1898		9. AGE (In years last birthday) 66		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE-PRESIDENT					10B. KIND OF BUSINESS OR INDUSTRY GROCERS ASSOCIATION					11. BIRTHPLACE (State or foreign country) BALTIMORE					12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HENRY BOHNLOFINK					14. MOTHER'S MAIDEN NAME CAROLINE BECHTOLD											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT MRS. CAROLINE BOHNLOFINK					ADDRESS 6103 MARLBORO BALT 12	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.111-260X (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) DUE TO Pulmonary embolism + Pleurisy					INTERVAL BETWEEN ONSET AND DEATH 3 days						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO Chn. myocarditis + Arteriosclerosis					Indefinite						
					(C) Former case Coronary Thrombosis					over 5 years ago						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Diabetes mellitus					years						
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE Nathaniel M Beck M.D.					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED May 6-65						
23C. PHYSICIAN'S NAME (Type) Nathaniel M. Beck					23D. ADDRESS 2818 St Paul St											
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 5-10-65					24C. NAME OF CEMETERY or CREMATORY PARKWOOD CEMETERY					24D. LOCATION (City, town, or county) (State) PARKVILLE BALT CITY MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965					25B. NAME OF REGISTRAR Robert E. Farber M.D.					25C. FUNERAL DIRECTOR Wm. Cook Brooks					ADDRESS 100 YORK RD TOWSON, MD.	





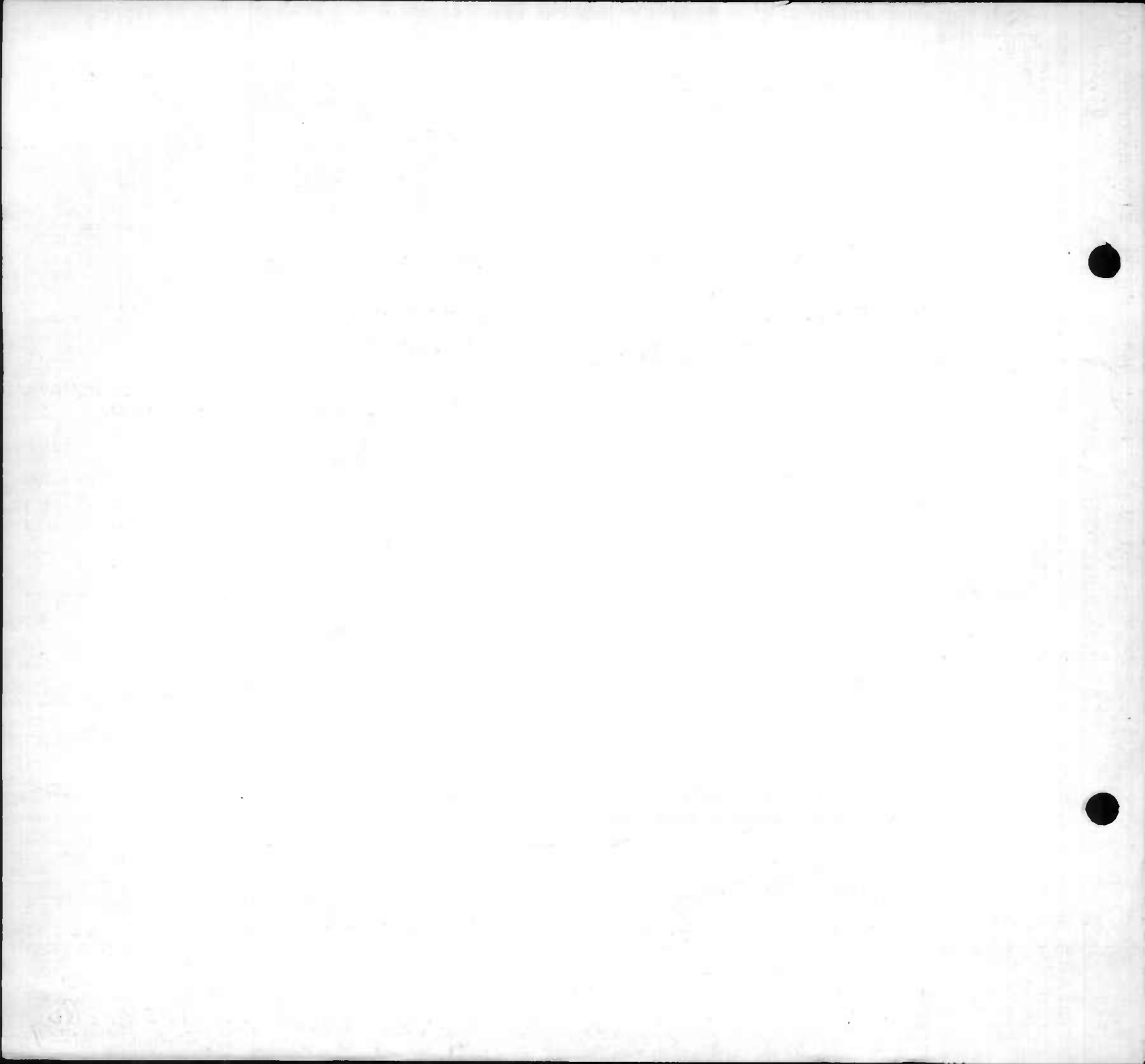




## FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 4937		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4937	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) LEONA GIBSON			
2. DATE AND HOUR OF DEATH May 3, 1965 17 15 A.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY 3-02			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 240 S. EDEN ST.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 3-1-88	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NOT EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME JOHN T. PARKS		14. MOTHER'S MAIDEN NAME EMMA EMILY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. L. HOEFNER ADDRESS 12 N. DECKER AVE BALT. MD.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Carcinoma of Cervix (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Congestive Heart Failure					
19A. DATE OF OPERATION 2 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-21 1965 to 5-3 1965, that (we) last saw the deceased alive on 5-3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		23A. SIGNATURE Paul A. Herzog		23B. DATE SIGNED 5-3-65	
23C. PHYSICIAN'S NAME (Type) PAUL A. HERZOG		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-6-65		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. MAY 10 1965		24F. NAME OF REGISTRAR Robert E. Farley	
24G. FUNERAL DIRECTOR Wm Cook Brooks Towson		24H. ADDRESS 1050 York Rd Towson MD 21204			



42-92-10 1

CRF

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 4938

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Julius Green

2. DATE AND HOUR OF DEATH

5-4-65

2:55 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland, 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1506 Latrobe Park Terrace, 21230

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

7-11-1886

78

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Car repairman

10B. KIND OF BUSINESS OR INDUSTRY

B&amp;O Railroad

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Green

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

705-10-1791

17. INFORMANT

ADDRESS

RECORDS: BCH, 4940 Eastern Ave., Balto., Md.

18.

331X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Bronchopneumonia  
DUE TO

ANTECEDENT CAUSES

(B) Right Cerebral Vascular Accident  
DUE TODISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from February 22 19 65 to May 4 19 65  
that (I) (we) lost saw the deceased alive on May 4, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 4, 1965

23C. PHYSICIAN'S  
NAME (Type)

HOWARD K. RATHBUN

23D. ADDRESS

M.D.

4940 Eastern Avenue, Baltimore, Md., 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5/7/65

24C. NAME of CEMETERY or CREMATORY

Holy Trinity Cemetery

24D. LOCATION

(City, town, or county)

(State)

Howard County, MD.

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Charles L. Stevens Funeral Home, Inc.

ADDRESS

1501 East Fort Avenue

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.S. 153

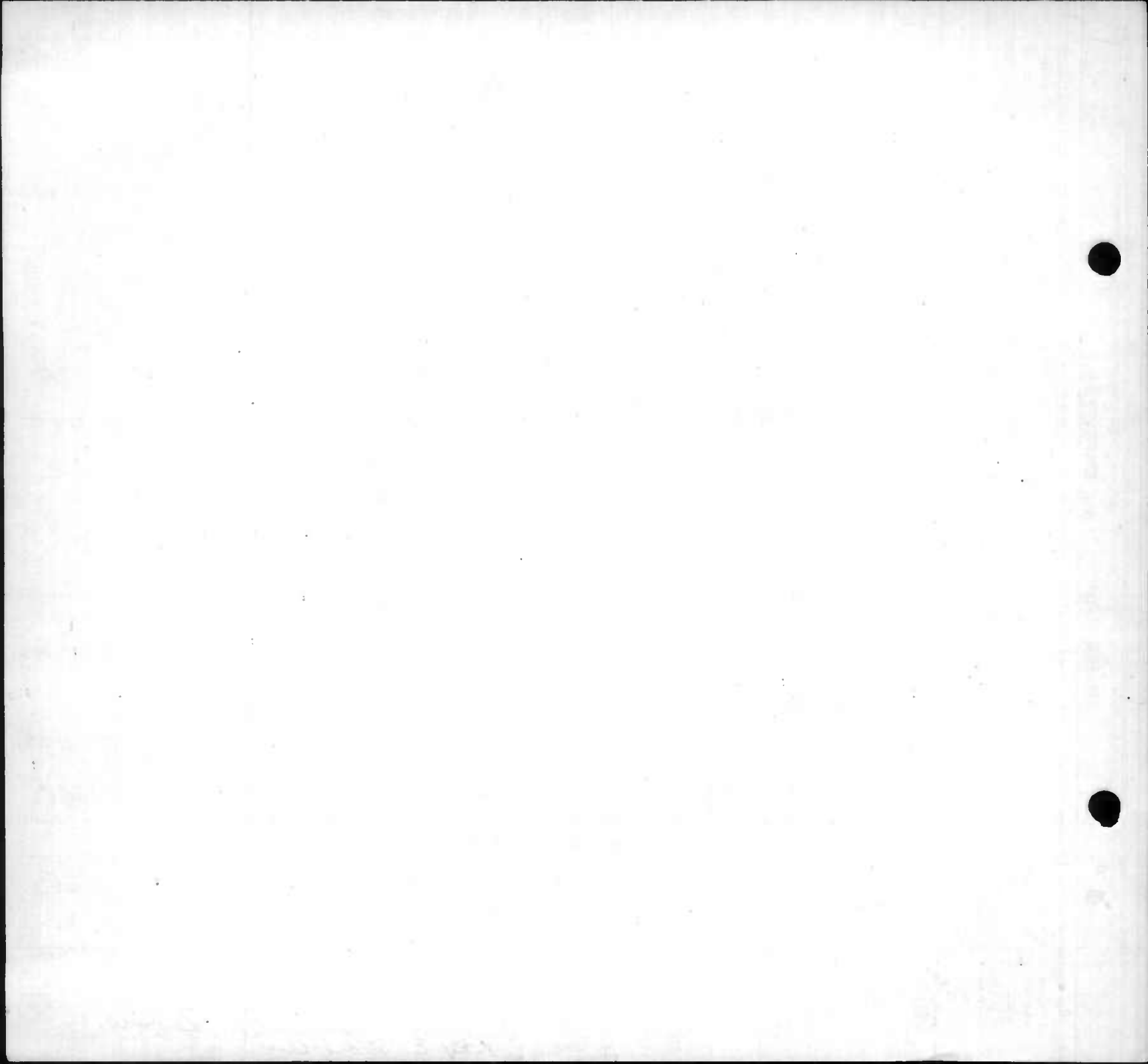
5-21-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

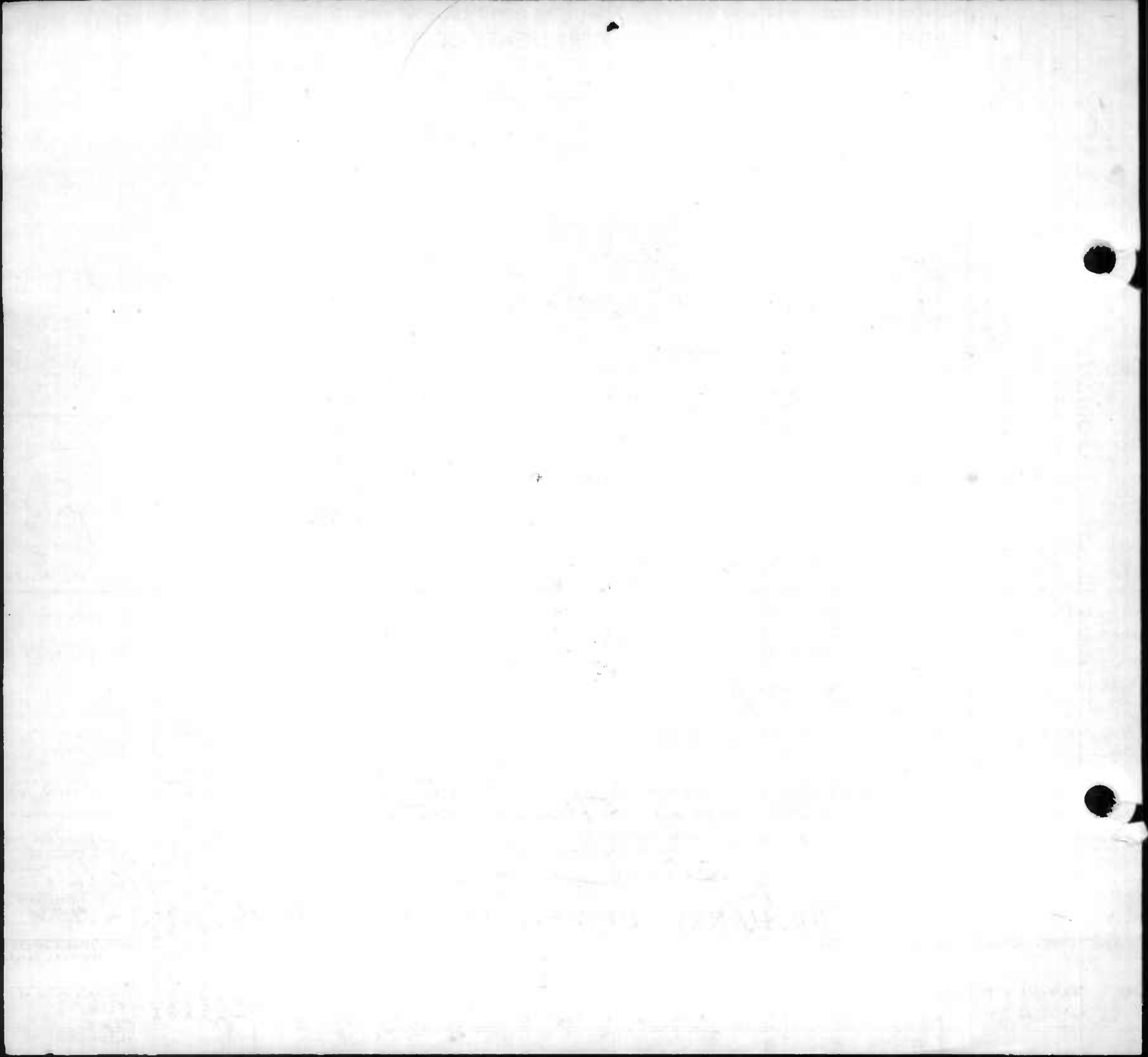
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 4939</u>	
BIRTH NO. <u>65 4939</u>		M.E. CASE NO. <u>65 4939</u>		1. NAME OF DECEASED (Type or Print) <u>JOSEPH EARL HAUNN SR.</u>		2. DATE AND HOUR OF DEATH <u>7 MAY 1965</u> <u>9:45 P</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>24-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>FRANKLIN SQUARE HOSPITAL</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1618 E. FORT AVENUE</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>FEB 25, 1899</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JOHN HAUNN</u>				14. MOTHER'S MAIDEN NAME <u>SARAH O'NEIL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>21803754</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <u>Pulmonary Embolism</u> DUE TO (B) <u>Phlebotrombosis Left lower extremity</u> DUE TO (C) <u>Post-Pneumectomy</u> DUE TO			
19A. DATE OF OPERATION <u>6 MAY 1965</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>LEFT LUNG TUMOR</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 26</u> 19 <u>65</u> to <u>MAY 7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>MAY 7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>ROLANDO F. DEL ROSARIO</u> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7 MAY 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLANDO F. DEL ROSARIO</u> M.D.				23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Rosary Cemetery Dundalk Md.</u>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Charles E. Stevens Funeral Home Inc.</u>		ADDRESS <u>1618 E. Fort Ave.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4940	
BIRTH NO. 65 4940		M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Chrest Petroff		2. DATE AND HOUR OF DEATH May 5, 1965 6:15 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1409 Haubert St.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1409 Haubert St.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 7-22-1892	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10B. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Masadonia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Petar Petrovski			
14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I			
16. SOCIAL SECURITY NO. 705-12-3567		17. INFORMANT ADDRESS William Petroff 1409 Haubert St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.1 I CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH Immediate		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CERTIFICATION APPROVED BY M.D. [Signature] 19. DATE OF OPERATION 0			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 1964 to 5/5 1965, that (I) (we) last saw the deceased alive on 5/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harry Deibel M.D.		23B. DATE SIGNED 5/10/65		23C. PHYSICIAN'S NAME (Type) DR. HARRY DEIBEL	
23D. ADDRESS 1206 Haver St Balto 30 md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR'S ADDRESS Charles L. Stevens Funeral Home, Inc. 4015 N. E. FORT AVENUE	

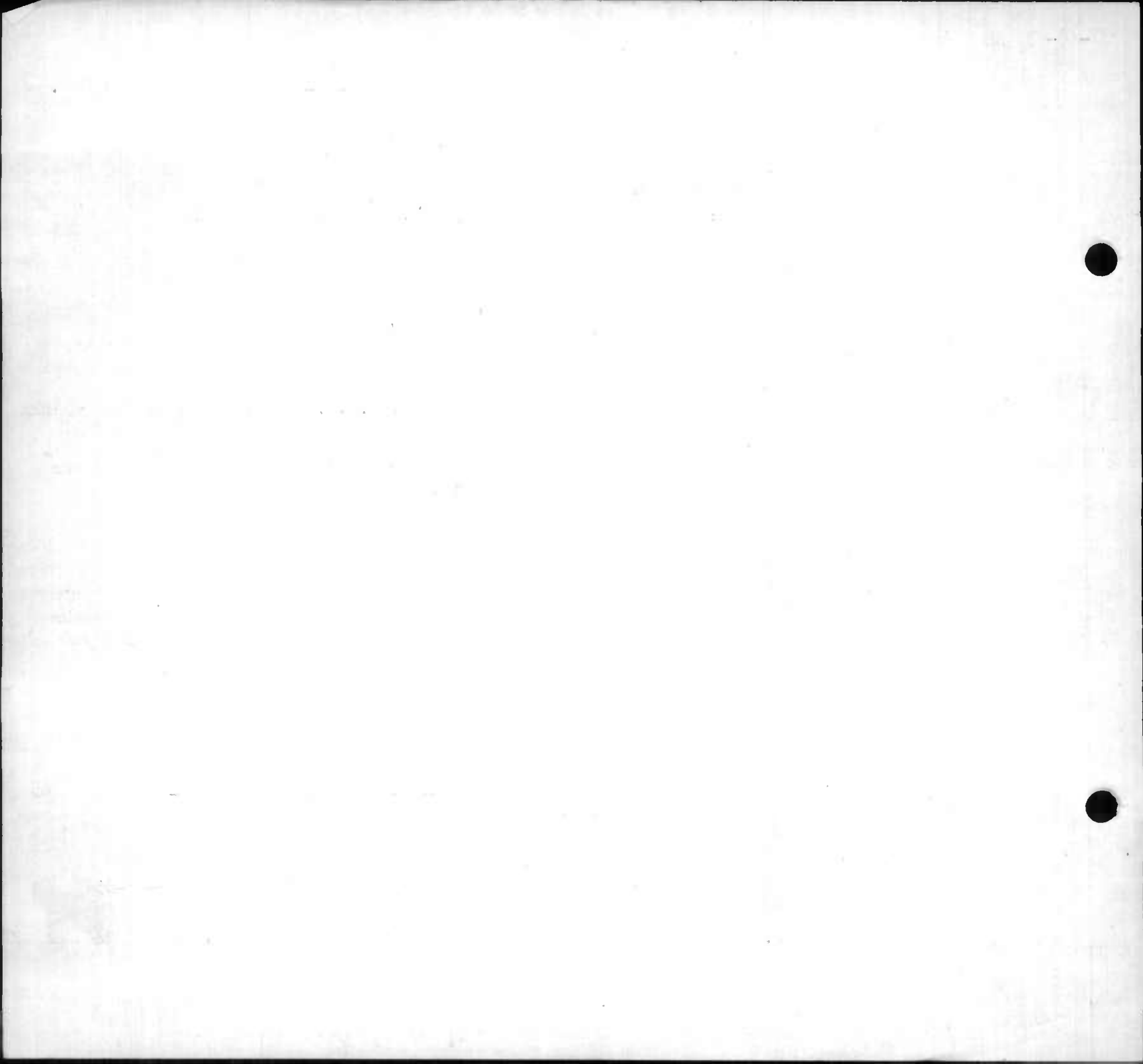




FUNERAL DIRECTOR: IMPORTANT

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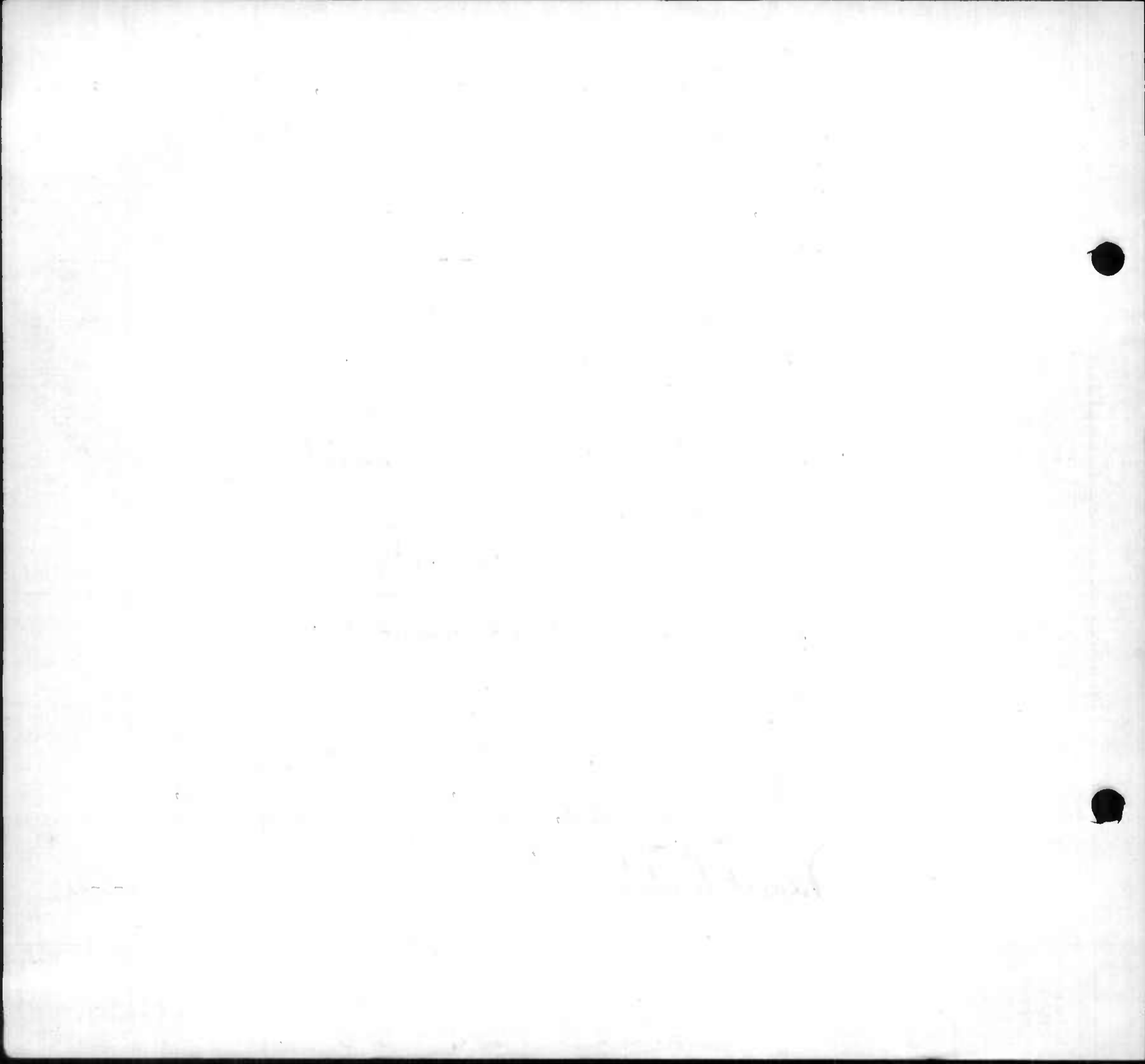
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				Registered No. <b>65 4941</b>	
BIRTH NO. <b>65 4941</b>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Randolph Harris</b>			2. DATE AND HOUR OF DEATH <b>4-26-65 1:30 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-12</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>4940 Eastern Avenue #21224</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	B. DATE OF BIRTH	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>331X1-260X</b> <b>Cerebrovascular Accidents</b> Recent and Remote			INTERVAL BETWEEN ONSET AND DEATH <b>8 Years</b>		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b> <b>Aspiration Pneumonia</b>			6 Months 3 Days		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>6-20-19 61</b> to <b>4-26-19 65</b> , that (I) (we) last saw the deceased alive on <b>4-26-19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dr. Charles Carpenter</b>				23B. DATE SIGNED <b>4-26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Charles Carpenter</b>				23D. ADDRESS <b>4940 Eastern Avenue #21224</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 10 1965</b>		25B. NAME OF REGISTRAR <b>John S. Feltz</b>		25C. FUNERAL DIRECTOR'S ADDRESS <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

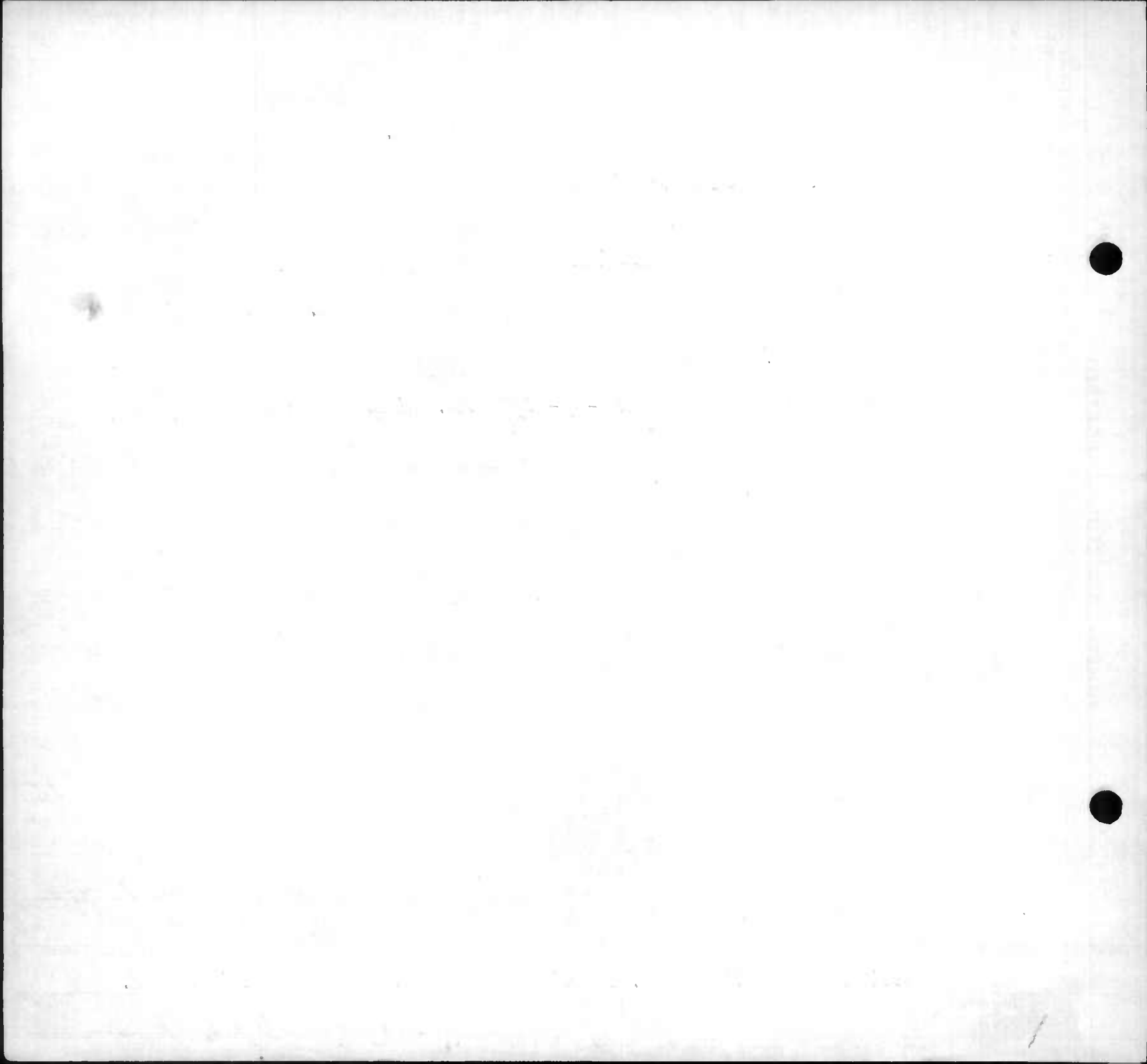
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4942</u>	
BIRTH NO. <u>65-10373</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <u>65 4942</u>					
1. NAME OF DECEASED (Type or Print) <u>Baby of Burnadette Evans</u>		2. DATE AND HOUR OF DEATH <u>May 1, 1965</u> <u>5:45 p.m.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>		A. STATE <u>Maryland</u> B. COUNTY <u>14-03</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>524 Laurens Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>5-1-65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days <u>12</u> <u>12</u> <u>20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>			
14. MOTHER'S MAIDEN NAME <u>Burnadette Evans</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>762.51</u> <u>Atelectasis pneumonia</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs 20 min.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) <u>Prematurity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<u>Small sub-arachnoid hemorrhage</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1965</u> 19 to <u>May 1, 1965</u> 19, that (I) (we) last saw the deceased alive on <u>May 1, 1965</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vincent R. Blake</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-3-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Vincent R. Blake</u>		23D. ADDRESS <u>1514 Division Street</u>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<u>MAY 6 1965</u>				<u>BALTIMORE</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. JUDICIAL DISTRICT	
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BGMH					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

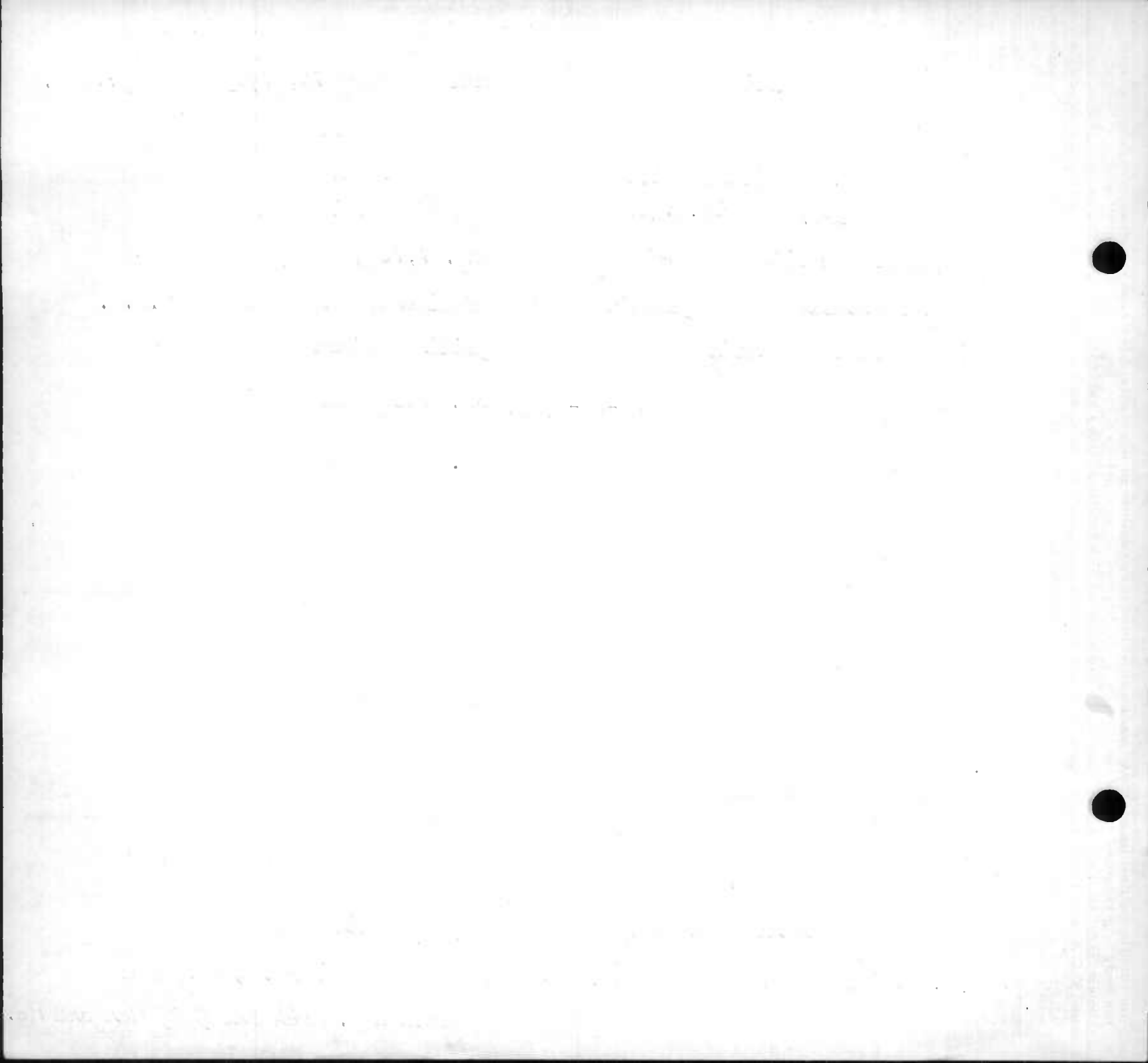
BALTIMORE CITY HEALTH DEPARTMENT									
65 4943					65 4943				
BIRTH NO.					Registered No.				
M.E. CASE NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>NOVAK Mr. Lea E.</u>					5-8-65 12 30 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bon Secours Hospital</u>					A. STATE <u>Md.</u> B. COUNTY <u>27-12</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO 12</u>				
					D. STREET ADDRESS (If rural, give location) <u>408 Evesham Ave</u>				
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>5-4-07</u>	9. AGE (In years last birthday) <u>58</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>IGNATIUS NOVAK</u>					14. MOTHER'S MAIDEN NAME <u>DORA GRONA</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-07-3157</u>		17. INFORMANT <u>Mrs. Mildred Novak</u>		ADDRESS <u>(Same)</u>		
18. <u>433.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) <u>Ventricular Tachycardia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic CVD</u>					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				
INTERVAL BETWEEN ONSET AND DEATH <u>days (1-2)</u> <u>years</u>									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>0</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> 19 <u>65</u> to <u>May 8</u> 19 <u>65</u> . that (I) <u>we</u> lost saw the deceased alive on <u>May 8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death.									
23A. SIGNATURE <u>Zenaida O. Palad</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>May 8, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>ZENAIDA O. PALAD</u>					23D. ADDRESS <u>Bon Secours Hosp. Fayette &amp; Palanski St.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/12/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1965</u>			25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>RUCK &amp; Leonard J. Ruck, Inc.</u>		ADDRESS		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4944					65 4944				
BIRTH NO.					Registered No.				
M.E. CASE NO. 65 4944									
1. NAME OF DECEASED (Type or Print) <i>Amelia</i>					2. DATE AND HOUR OF DEATH <i>Muth</i>		3. DATE AND HOUR OF DEATH <i>May 10, 1965</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>House in the Pines</i>					A. STATE <i>Maryland</i>				
5837 Belair Road					8. COUNTY <i>27-01</i>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				
					D. STREET ADDRESS (If rural, give location) <i>4202 Belair Road</i>				
5. SEX <i>female</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i>		8. DATE OF BIRTH <i>Aug. 1, 1895</i>		9. AGE (In years last birthday) <i>69</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Palthaser Martin</i>					14. MOTHER'S MAIDEN NAME <i>Emilie Simon</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>213-10-3403</i>		17. INFORMANT ADDRESS <i>Mrs. Harry Rahley</i>		
18. <i>153.8 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES					INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <i>Hepatic Coma</i> <i>4 days</i>				
					(B) <i>Metastatic Carcinoma</i> <i>6 m.</i>				
					(C) <i>Adenocarcinoma of Colon</i> <i>1 year</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While <input type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>5/8</i> 19 <i>65</i> to <i>5/10</i> 19 <i>65</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>5/8</i> 19 <i>65</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.									
23A. SIGNATURE <i>Albert B Bradley</i>					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <i>5/10/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Albert Bradley</i>					23D. ADDRESS M.D. <i>4900 Belair Road</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/12/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Rubk Inc 5305 Harford Rd.</i>					





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

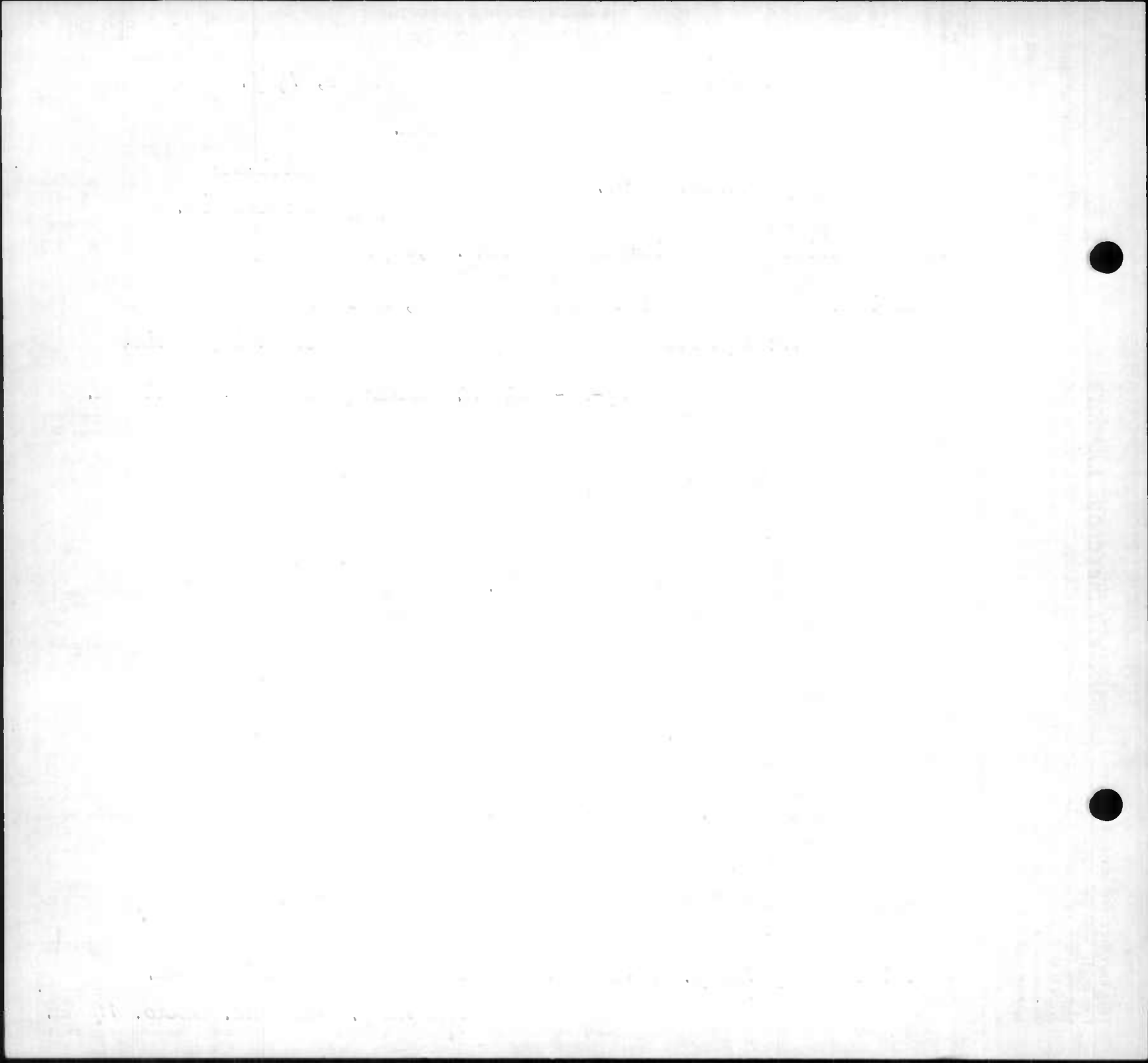
BIRTH NO. 65 4945		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4945	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Edith Romoser</i>		2. DATE AND HOUR OF DEATH <i>May 9, 1965</i>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>908 E. Preston St.</i>		A. STATE <i>Md.</i> B. COUNTY <i>9-09</i>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
		D. STREET ADDRESS (If rural, give location) <i>908 E. Preston St.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i>	8. DATE OF BIRTH <i>Aug. 3, 1876</i>	9. AGE (In years last birthday) <i>88</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>Usa</i>		13. FATHER'S NAME <i>? Kent</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, go on or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-3857</i>		17. INFORMANT ADDRESS <i>Mr. James Romoser 3101 Evergreen Ave.</i>	
18. <i>782.4 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>5/9</i> <i>5/9</i> 19 <i>65</i> to <i>5/9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5/9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Marcos Revin</i> M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/10/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARCOS REVIN</i>		23D. ADDRESS <i>201 Wise Ave</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/12/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>	
25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto.</i>		ADDRESS <i>Md. 21214</i>			



# FUNERAL DIRECTOR: IMPORTANT

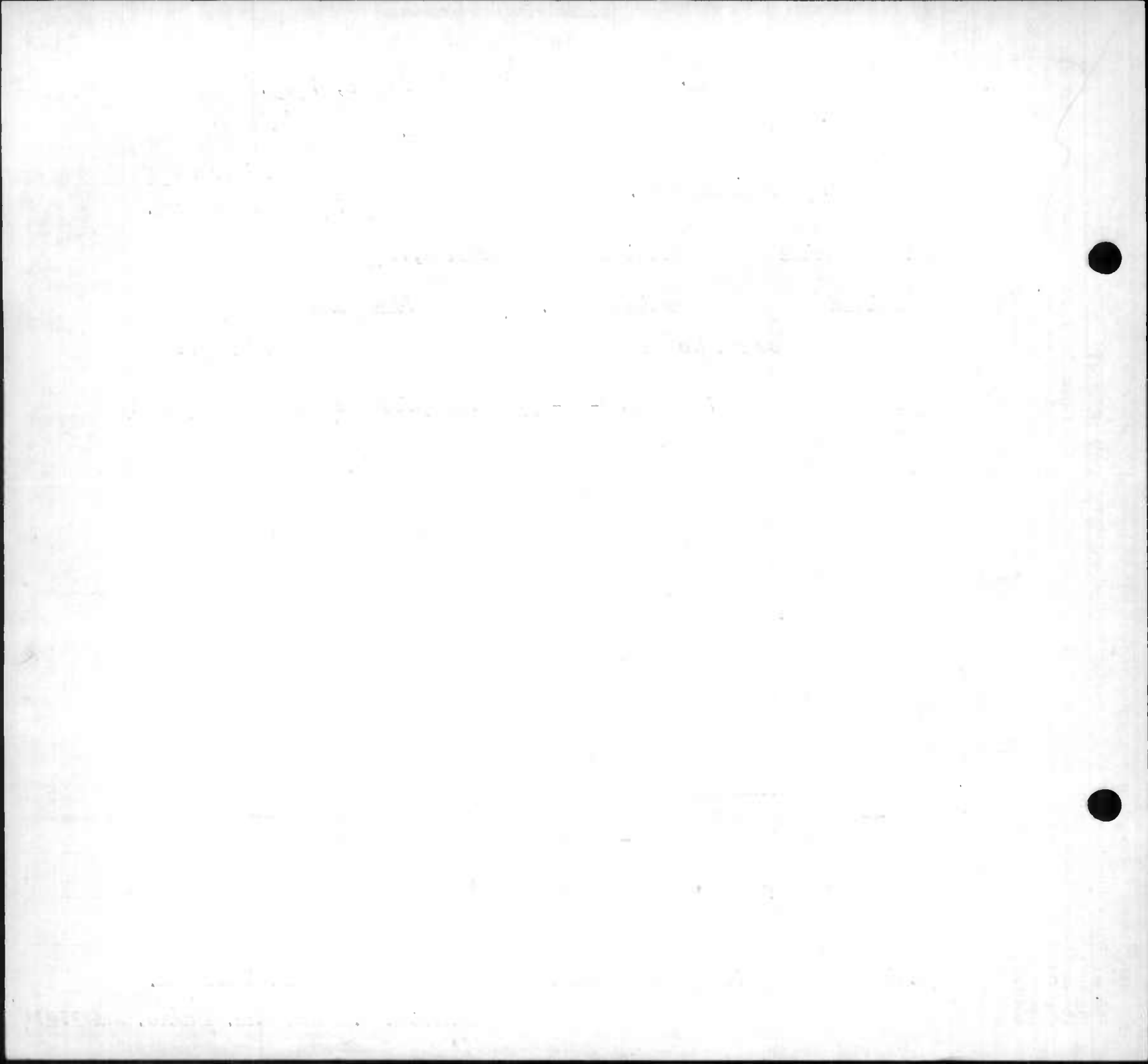
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH					Registered No. 65 4946					
BIRTH NO. 65 4946					M.E. CASE NO. 65 4946					
1. NAME OF DECEASED (Type or Print) Joseph Goertz					2. DATE AND HOUR OF DEATH May 8, 1965.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4247 Sheldon Ave.					A. STATE Md. B. COUNTY 26-02					
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					D. STREET ADDRESS (If rural, give location) 4247 Sheldon Ave.					
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH Aug. 8, 1871		9. AGE (In years last birthday) 93		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Hugo Goertz					14. MOTHER'S MAIDEN NAME Fredrika Schick					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 214-78-1382		17. INFORMANT ADDRESS Mr. Walter Goertz Annapolis Md.			
18. 720.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Chronic Cardiac Decompensation (B) Coronary Arteriosclerosis (C) Cerebral Arteriosclerosis (v1)					
19. 720.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					INTERVAL BETWEEN ONSET AND DEATH 5 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 19 47 to May 8 19 65, that (I) (we) last saw the deceased alive on April 29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Melvin F. Pohorik M.D.					23B. DATE SIGNED 5/10/65			23C. PHYSICIAN'S NAME (Type) MELVIN F. POHORIK M.D.		
23D. ADDRESS 3603 Belair Road Balto. Md.										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5/11/65			24C. NAME OF CEMETERY or CREMATORY London Park Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT MAY 10 1965					25B. NAME OF REGISTRAR Robert E. Fisher			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. 14 Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
65 4947 CERTIFICATE OF DEATH					Registered No. 65 4947				
BIRTH NO. 65 4947					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) Jay C. Dobbs					2. DATE AND HOUR OF DEATH May 8, 1965. 6:05 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3214 Woodhome Ave.					A. STATE Md.				
					B. COUNTY				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #34					D. STREET ADDRESS (If rural, give location) 3214 Woodhome Ave.				
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH March 8, 1895	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Police Dept.		11. BIRTHPLACE (State or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Dobbs					14. MOTHER'S MAIDEN NAME Jennie Carr				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1			16. SOCIAL SECURITY NO. 212-32-8758		17. INFORMANT Mrs Edith Dobbs			ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of sigmoid colon with generalized metastasis 6 yrs. (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH				
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION June 1964			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resection of colon		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from February 19 65 to May 8 19 65, that (I) (we) last saw the deceased alive on May 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Lloyd E. Saylor, M.D.					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED May 10, 1965	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (specify) Burial		24B. DATE 5/11/65		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965			25B. NAME OF REGISTRAR Robert E. Fairbank			25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md 21214			



43-34-99 AM

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4948

BIRTH NO.

65 4948

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Marion E. Jones

2. DATE AND HOUR OF DEATH

5-4-65

2:45 P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3323 Gwyns Falls Parkway #21216

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-20-03

9. AGE (In years  
last birthday)

61

(If Under 1 Yr. Under 24 Hrs.  
Months Days Hours Min.)10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Willie Wynn

14. MOTHER'S MAIDEN NAME

Ida Greenhill

15. Was Deceased Ever in U. S. Armed Forces  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 153.8 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, oshtenio, etc. It means the disease,  
injury or complication which caused death.)(A) Gram Negative Septicemia  
DUE TO

14 Hours

ANTECEDENT CAUSES

(B) Metastatic Adeno Carcinoma of Colon 8 Months  
DUE TODISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At  
Work ☐Not While  
At Work ☐22. I certify that (I) (this hospital) attended the deceased from 4-23- 19 65 to 5-4- 19 65,  
that (I) (we) last saw the deceased alive on 5-4- 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Zieve M.D.

Attending  
Phys. ☐Med.  
Director ☐Stoll  
Phys. ☒

23B. DATE SIGNED

5-4-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Philip Zieve

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial 5-8-65

Spring Hill

Blackstone

V.A.

25A. DATE RECD BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAY 10 1965

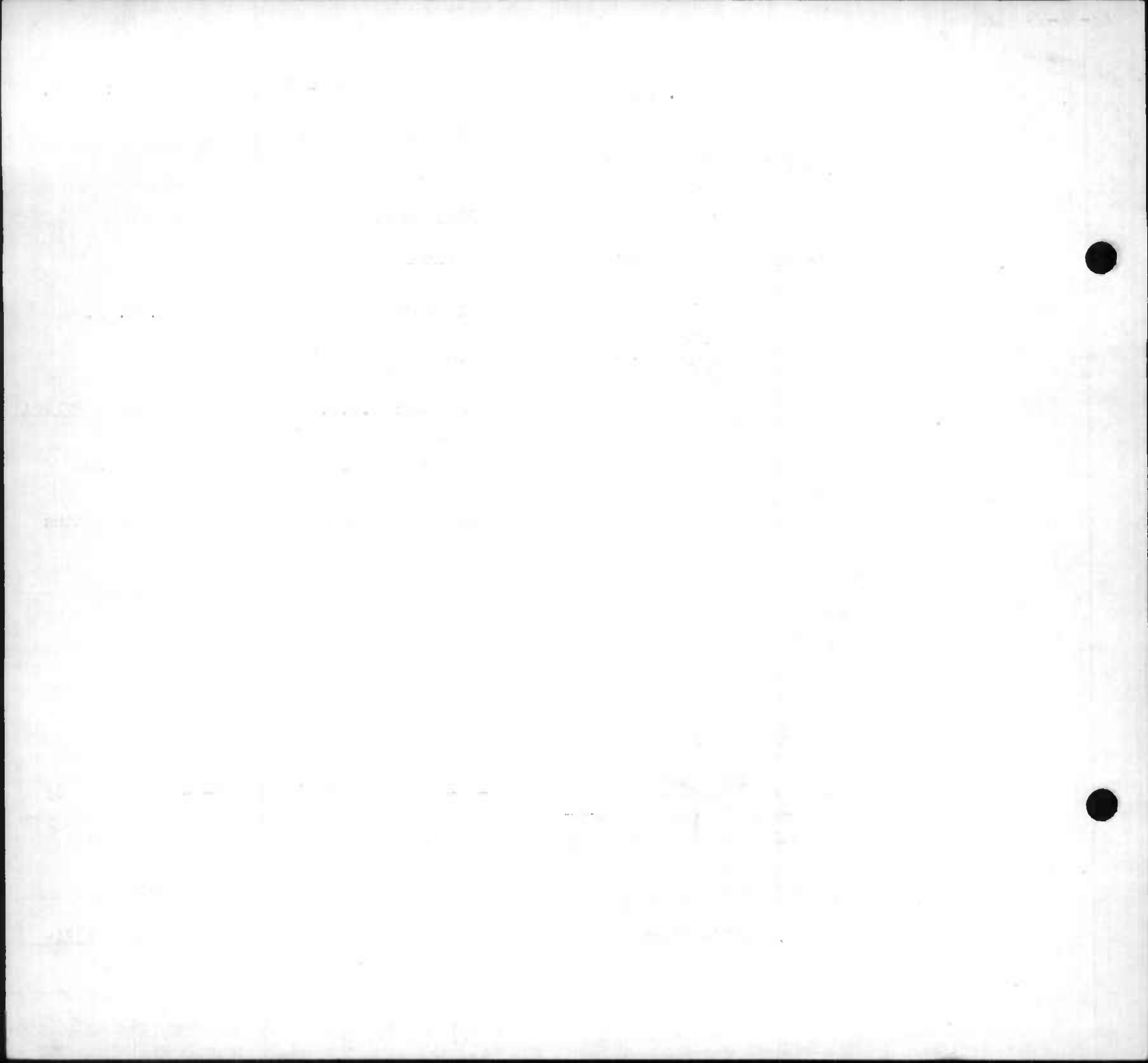
Robert E. Parker

Y. Y. Scott

Blackstone, V.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





65 4949

BALTIMORE CITY HEALTH DEPARTMENT

65 4949

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MATHEW DASHIELDS

2. DATE AND HOUR PRONOUNCED DEAD

May 4, 1965

7:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

502 W. Preston St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

502 W. Preston St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-19-1900

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Matt Dashields

14. MOTHER'S MAIDEN NAME

Kitty Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Martin Dashields 1247 Mt. Olivet Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

House

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

502 W. Preston St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 4 65 p m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Allegedly fell down stairs

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5-5-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-8-65

23C. NAME of CEMETERY or CREMATORY

John Wesley

23D. LOCATION

(City, town, or county)

(State)

Deal Island

MD.

24A. DATE REC'D BY HEALTH DEPT.

MAY 10 1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

G.L. Webster

ADDRESS

Deal Island, MD.

12-18-1990  
W. J. ...  
...

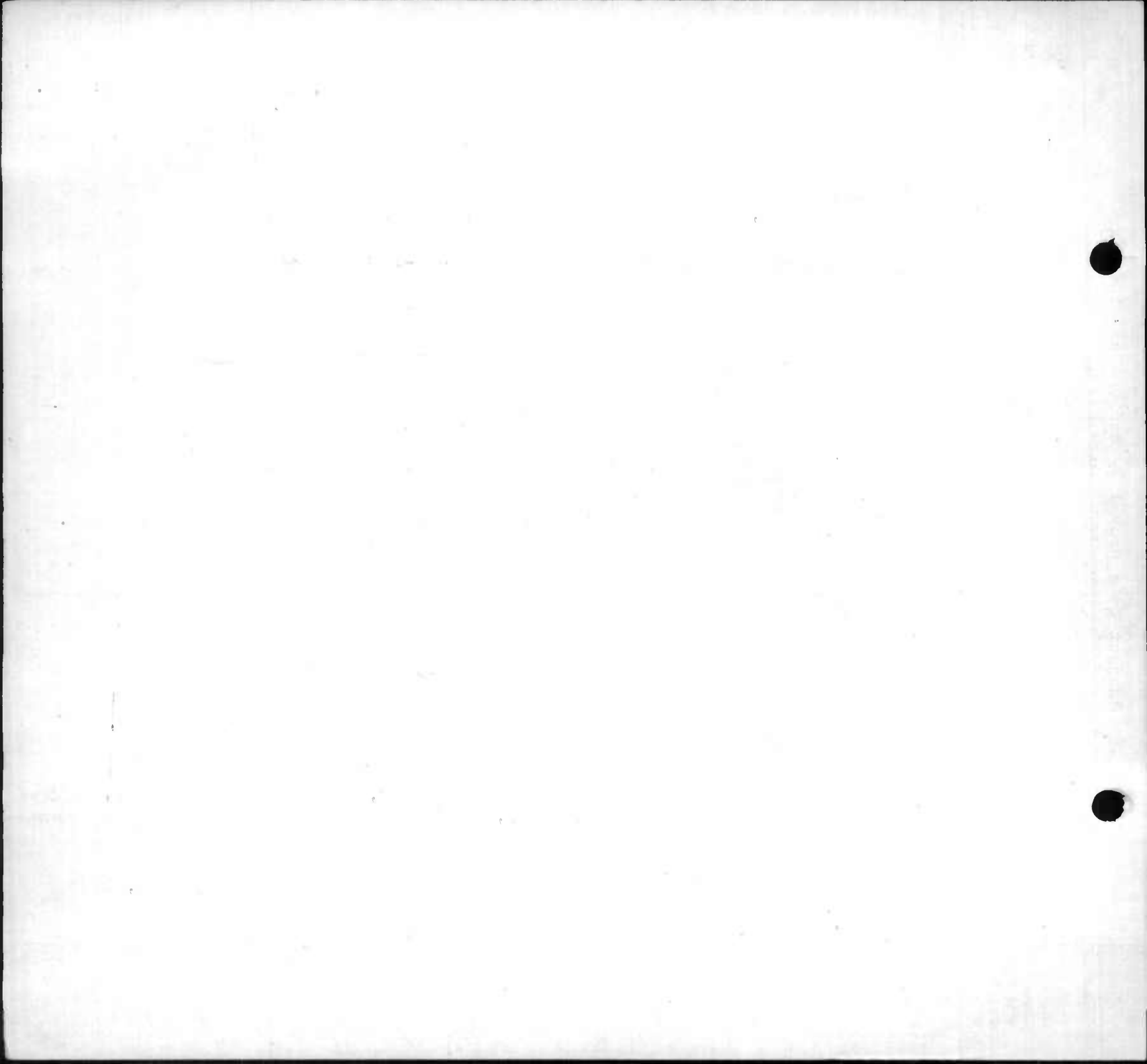
...

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Subject to approval by medical examiner  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4950	
BIRTH NO. 65 4950		CERTIFICATE OF DEATH		65 4950	
1. NAME OF DECEASED (Type or Print) Dan Coleman		2. DATE AND HOUR OF DEATH May 5, 1965 1:50 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1721 Pulaski Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-21-1908	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bowling Green, U.A.	
13. FATHER'S NAME Lee Coleman		14. MOTHER'S MARRIEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 279-23-8222		17. INFORMANT Mary Coleman	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		19. CAUSE OF DEATH (A) Arteriosclerotic cardio-vascular (B) disease (C) INTERVAL BETWEEN ONSET AND DEATH 2 years.		ADDRESS Same	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from February 20, 1965 to February 27, 1965, that (I) (we) last saw the deceased alive on February 27, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED May 6, 1965	
23C. PHYSICIAN'S NAME (Type) Roland T. Smoot		23D. ADDRESS M.D. 3817 Copley Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-65		24C. NAME OF CEMETERY OR CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore MD		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1965			
25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR		25D. ADDRESS 1727 N. Mount St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 4951					CERTIFICATE OF DEATH					Registered No. 65 4951									
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH									
					MRS. REBECCA ROSENBERG					5/10/65 9 <sup>30</sup> A. M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY									
Mercy Hospital, Balto, Md										MARYLAND 15-38									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
										BALTIMORE									
										D. STREET ADDRESS (If rural, give location)									
										3513 Fairview Ave									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.							
FEMALE		White		Married		[REDACTED]		86											
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)									
Housewife					At Home					RUSSIA									
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					12. CITIZEN OF WHAT COUNTRY?									
Abraham Merin					Froma?					U.S.A.									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS									
NO					NO					Mr. Nathan Rosenberg 3513 Fairview Ave.									
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
420.1 I										Cardiac Arrhythmia					Recent				
ANTECEDENT CAUSES										(A) DUE TO									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(B) DUE TO					Myocardial infarction				
										(C) DUE TO					ASCVD				
II										Congest. Heart failure									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.										20A. AUTOPSY (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
19A. DATE OF OPERATION										19B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
None - expect cut down @ ankle																			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
no																			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 5/8/65 to 5/10/65, that (I) (we) lost saw the deceased alive on 5/10/65, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.																			
23A. SIGNATURE										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED				
W.E. Schwartz															5/10/65				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
W.E. SCHWARTZ										Mercy Hospital Balto									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Burial					5/11/65					Rebun Friendship					Baltimore, Maryland				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR					ADDRESS				
MAY 11 1965					Robert E. Taylor, M.D.					Al Lerman & Son Inc. 606 Ruston St.					124				

Mercy Hospital  
Baltimore, Md

2213 Fennell Ave

~~86~~

Kassia  
Frome

F W  
M  
Hennrich  
Cabrera Martin

Charles Carpenter  
Myrtlewood Avenue  
Baltimore

Adon

Woods-Whitcomb  
George Washington  
Baltimore

no

2/10/02  
2/10/02  
2/10/02

W E Schwartz  
W E Schwartz

Mercy Hospital  
Baltimore

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4952				CITY HEALTH DEPARTMENT		REGISTERED NO. 65 4952	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>HERMAN GORDON</b>				2. DATE AND HOUR OF DEATH <b>6:20 PM - 15/8/65 M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>7 Mercy Hospital</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>11-02</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BAITIMORE, MD.</b>			
				D. STREET ADDRESS (If rural, give location) <b>808 ST. PAUL ST. MIDTOWN Nursing Home</b>			
5. SEX <b>male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>12-18-08</b>	9. AGE (In years last birthday) <b>36</b>	10. UNDER 1 Yr. Months: Days		11. UNDER 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC GORDON</b>				14. MOTHER'S MAIDEN NAME <b>LENA - UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-05-9248</b>		17. INFORMANT <b>Hospital Records</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>286.31</b>				CAUSE OF DEATH (A) <b>Malnutrition + Dehydration</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Months.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Chronic Lung Disease; Paralytic Spinal Cord Disease</b>							
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5-5-65</b> to <b>5-8-65</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>5-8-65</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert L. Doyle</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5-8-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert L. Doyle</b>				23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/10/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chel Sharon</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Prof. Ferguson &amp; Son Inc. 6010 Rusttown</b>			



1

South of  
August 1

with 1/2

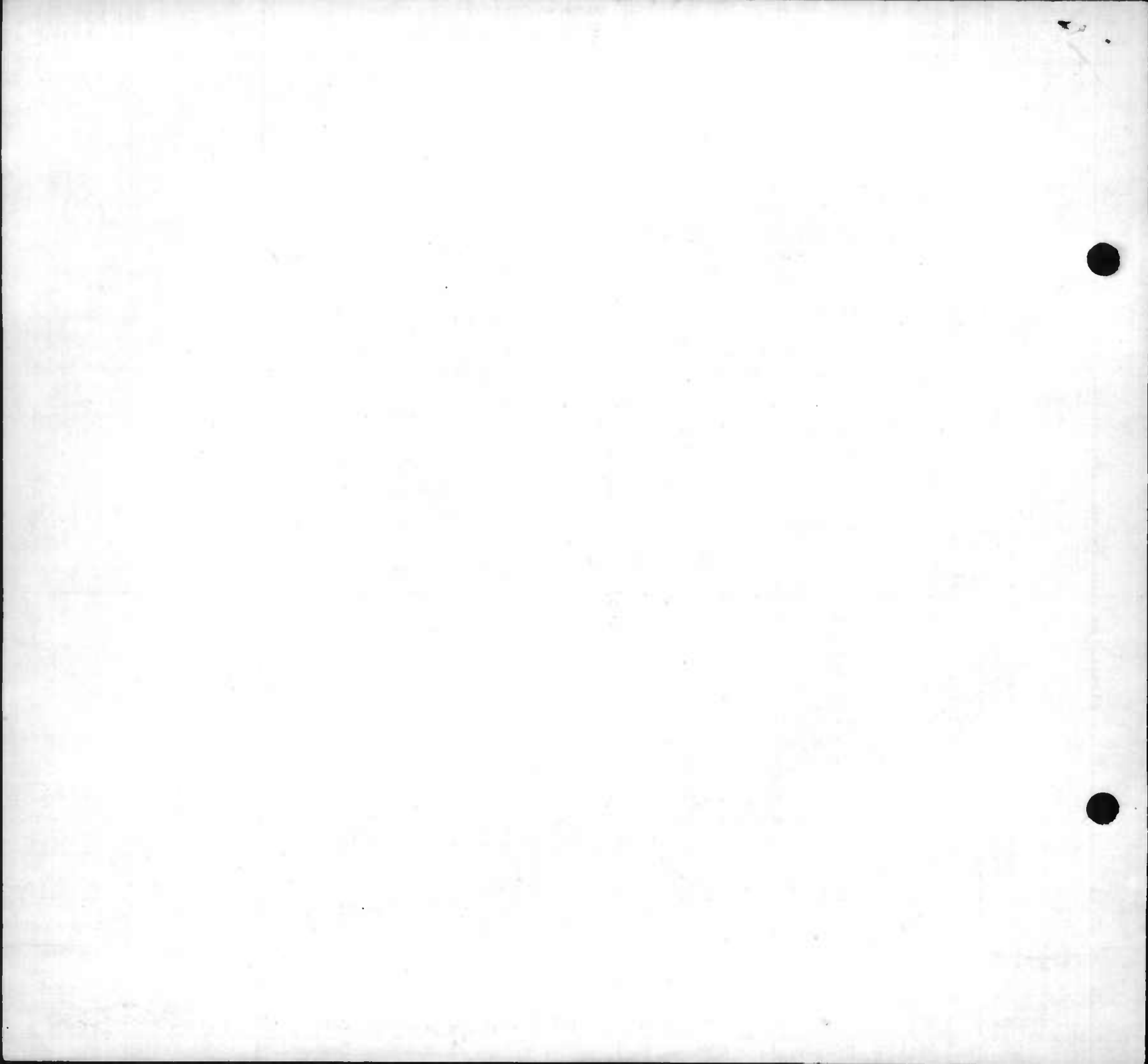
5/7/8



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.				M.E. CASE NO.		65 4953		CITY HEALTH DEPARTMENT		65 4953	
1. NAME OF DECEASED (Type or Print)						2. DATE AND HOUR OF DEATH					
LEONARD A. SUSSMAN						MAY 9, 1965 6:15 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)						A. STATE B. COUNTY					
MONTSEBELLO STATE HOSP.						MARYLAND 27-20					
C. CITY OR TOWN (If outside city limits, write RURAL and give township)						Baltimore					
D. STREET ADDRESS (If rural, give location)						3112 BANCROFT RD.					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. If Under 1 Yr. Months: Days	
Male		White		MARRIED		7/4/24		40			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
Clerk				Typist				MARYLAND			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
U.S.A.				JACOB SUSSMAN				ANNA METH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Not Known				219-18-5901				MRS. Rose Sussman 3112 Bancroft Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						CAUSE OF DEATH					
350X1						Bronchopneumonia					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						Interval BETWEEN ONSET AND DEATH					
						+ 4 yrs					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						Interval BETWEEN ONSET AND DEATH					
						+ 4 yrs					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
2								YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR?			
				Hospital				Montebello State Hospital			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
5 4 65 ?								Fall on Floor			
22. I certify that (I) (this hospital) attended the deceased from Nov 7 1963 to May 9 1965, that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE						23B. DATE SIGNED					
Reuben C. Guerrero M.D.						5/9/65					
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS					
REUBEN C. GUERRERO						Montebello State Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
Burial				5/10/65				Mikael Kodesh Beth Israel			
24D. LOCATION (City, town, or county) (State)				25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
Herring Run Maryland				MAY 11 1965				Robert E. Fink			
25C. FUNERAL DIRECTOR ADDRESS				25D. FUNERAL DIRECTOR				25E. FUNERAL DIRECTOR			
				Elberington & Bros. Baltimore							



BIRTH NO.

65 4954

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOEL H. ROSENHEIM

2. DATE AND HOUR PRONOUNCED DEAD

May 8, 1965

5:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

505 W. University Parkway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

PROPRIETOR

10B. KIND OF BUSINESS OR INDUSTRY

PRINTING

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

EMANUEL ROSENHEIM

14. MOTHER'S MAIDEN NAME

STELLA SAMUELS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW 2 NAVY

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

GILBERT FRIEDEL 808 COURT SQUARE BLDG

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Doriden Intoxication.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH? Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

505 W. University Parkway

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 8 '65

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Overdose of Doriden.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/9/65

23A. BURIAL CREMATION,  
REMOVAL, etc.

BURIAL

23B. DATE

5/10/65

23C. NAME OF CEMETERY or CREMATORY

HEBREW FRIENDSHIP

23D. LOCATION

(City, town, or county)

BALTIMORE

MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

SOL LEVINSON &amp; BROS. INC.

ADDRESS

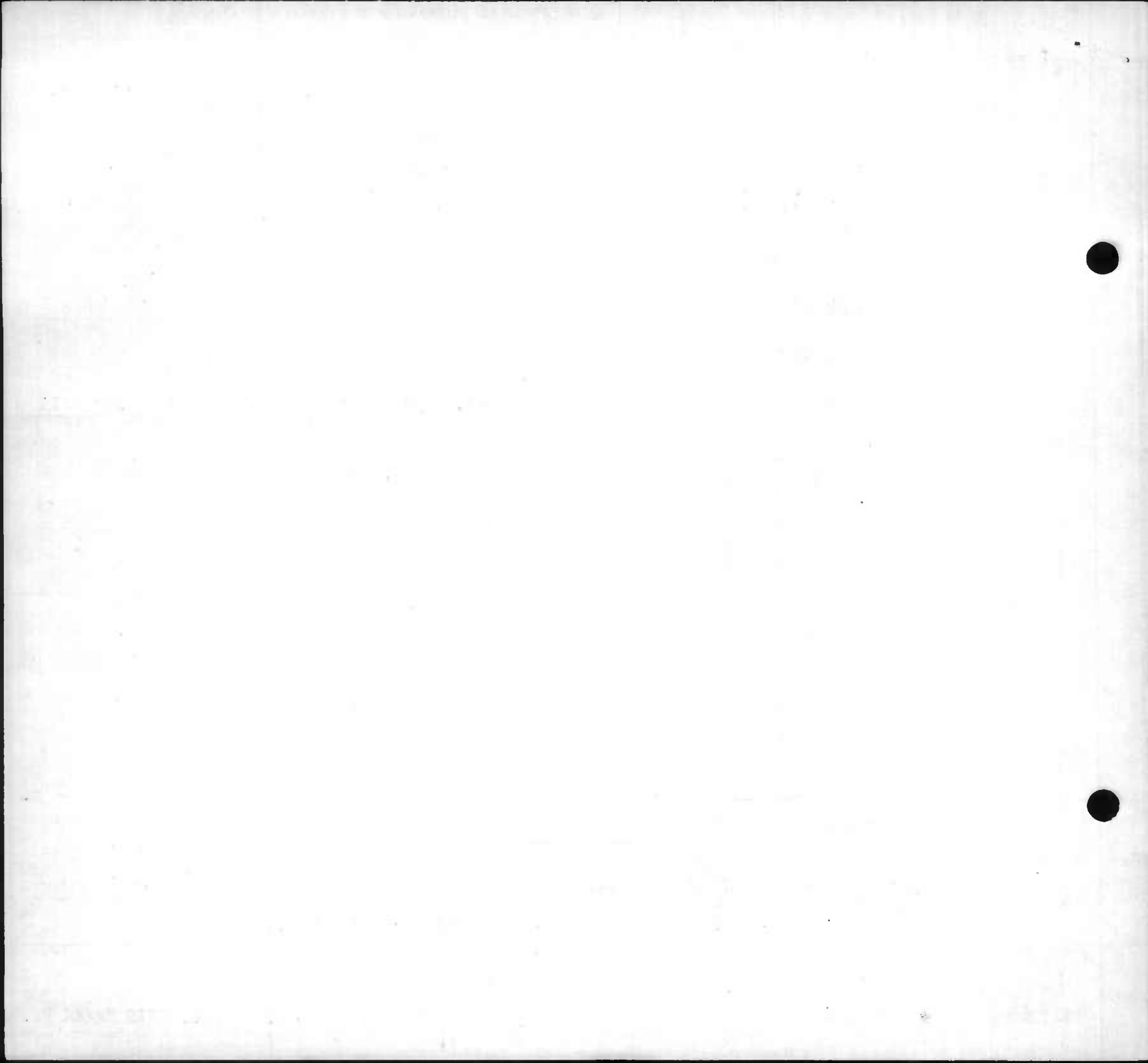
6010 REISTERSTOWN RD

WALLING FORD

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

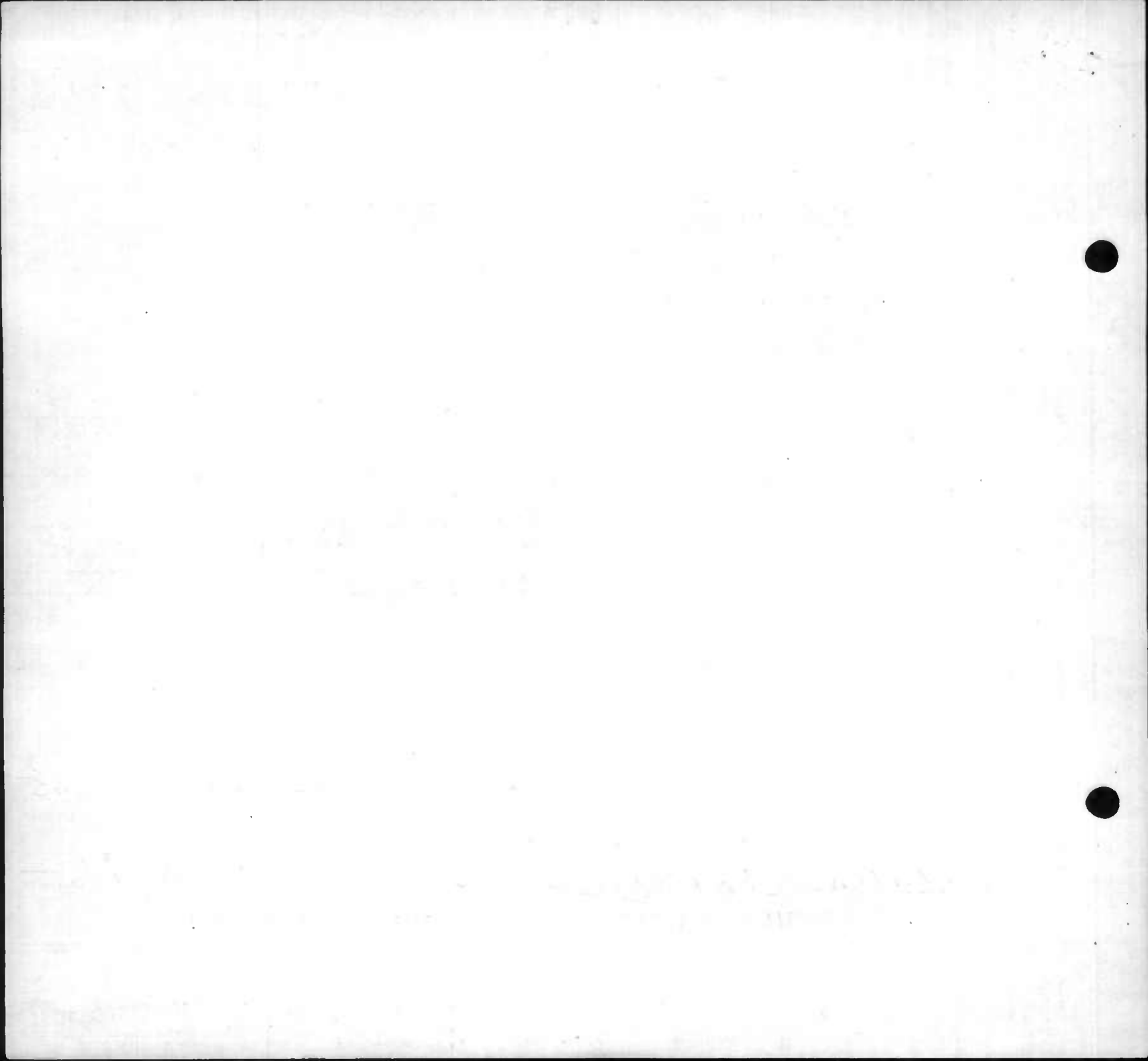
BALTIMORE CITY HEALTH DEPARTMENT																
65 4955					CERTIFICATE OF DEATH					Registered No. 65 4955						
BIRTH NO.					M.E. CASE NO.					2. DATE AND HOUR OF DEATH						
1. NAME OF DECEASED (Type or Print)					JENNIE COHEN					May 9, 1965 6:45 A. M.						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION  Mt. Sinai Nursing Home 4613 Park Heights Avenue					A. STATE					B. COUNTY						
					Maryland					15-13						
					C. CITY OR TOWN (If outside city limits, write RURAL and give township)											
					D. STREET ADDRESS (If rural, give location)											
					2620 Loyola Southway											
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.				
Female		White		Widowed				78								
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?				
Housewife				At Home				Russia				USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME											
Unknown					Unknown											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS				
							Mr. Charles Cohen					3815 Grantley Road #15				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH						
I					Acute myocardial infarction					1 day						
ANTECEDENT CAUSES					Generalized arteriosclerosis					Squash						
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																
II																
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR?			(If in Baltimore City, give exact location)								
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?											
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>														
22. I certify that (I) (this hospital) attended the deceased from March 19 65 to May 9 1965.																
that (I) (we) last saw the deceased alive on May 9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE					23B. DATE SIGNED											
Seymour Rubin					May 9, 1965											
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS											
Seymour Rubin					3312 Olympia Avenue											
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county)			(State)						
Burial		5/9/65		Knesseth Israel Kolb Wdlyn			Baltimore, Maryland									
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS								
MAY 11 1965		Robert E. Fajans			Sol Levinson & Bro.s			Inc. 6010 Reist Rd.								



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 4956</span>	
65 4956				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		MAGGIE BLOCH		MAY 7, 1965 11:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		B. COUNTY	
BELVEDERE NURSING HOME 2525 W. BELVEDERE AVE		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
		BALTIMORE		D. STREET ADDRESS (If rural, give location)	
		3325 CLARKS LANE			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED		86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE		AT HOME		RIGA EUROPE	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
ABRAHAM SHAPIRO		YETTA WEINBERG		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NO		MRS. SADIE SOBELMAN 3514 LABYRINTH RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Cardio-Respiratory Failure DUE TO Congestive Heart Failure (B) Arteriosclerosis C.U.I.D. DUE TO Generalized + Cerebral arteriosclerosis (C) Senility			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Oct 4 1958 to May 7 1965, that (I) (we) last saw the deceased alive on May 7 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Willard Applefeld M.D.				5/8/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
WILLARD APPLEFELD		5901 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		5/9/65		MIKRO KODESH BETH ISRAEL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 11 1965 Robert E. Fink M.D.				SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



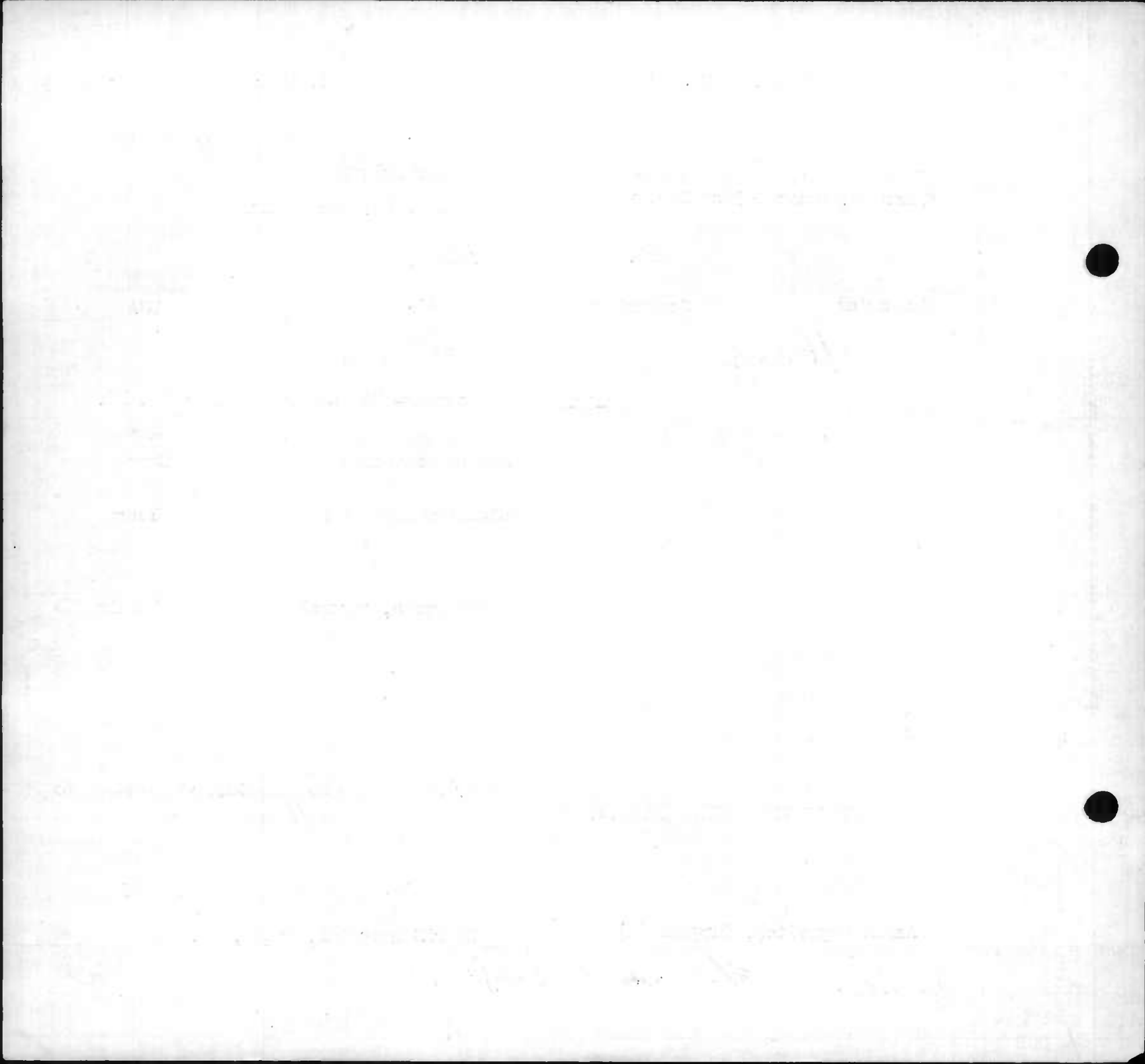


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <u>65 4957</u>				
BIRTH NO. _____ M.E. CASE NO. <u>65 4957</u> 1. NAME OF DECEASED (Type or Print) <u>GUSTAVE RAY ZIEGLER</u>					2. DATE AND HOUR OF DEATH <u>May 6, 1965</u> <u>1:50</u> P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>US Public Health Service Hospital</u> <u>Wyman Pk. Drive &amp; 31st Street</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>La.</u> B. COUNTY _____ C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>New Orleans</u> D. STREET ADDRESS (If rural, give location) <u>1011 St. Rock Avenue</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Wid.</u>		8. DATE OF BIRTH <u>4/14/05</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafaring</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Seafaring</u>		11. BIRTHPLACE (State or foreign country) <u>La.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>? Henry</u>					14. MOTHER'S MAIDEN NAME <u>? Emma Ray</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>434-14-8599</u>		17. INFORMANT ADDRESS <u>Records- US PHS Hospital, Balto, Md.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <u>327.1xL200.1</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH	
					(A) <u>Lobular pneumonitis</u>			<u>Days</u>	
					(B) <u>Pulmonary emphysema</u>			<u>Years</u>	
					(C) _____			_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					<u>Lymphosarcoma, generalized</u>			<u>Months</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15</u> 19 <u>65</u> to <u>May 6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <u>not</u> view the body after death.									
23A. SIGNATURE <u>Aaron Lupovitch</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>5/7/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Aaron Lupovitch, Surgeon (R)</u>					23D. ADDRESS M.D. <u>US PHS Hospital, Balto, Md.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>5/8/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Saint-Roch #2</u>		24D. LOCATION (City, town, or county) (State) <u>New Orleans, La.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1965</u>			25B. NAME OF REGISTRAR <u>E. J. ...</u>			25C. FUNERAL DIRECTOR ADDRESS <u>Capally 300 Mace</u>			



BIRTH NO. 65 4958 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE Milnes AUSTIN Sr.</b>				2. DATE AND HOUR PRONOUNCED DEAD <b>May 9, 1965 3:50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-03</b> D. STREET ADDRESS (If rural, give location) <b>2707 N. Calvert Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6-23-1898</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Attorney</b>		11. BIRTHPLACE (State or foreign country) <b>Waynesboro, Va.</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Dr. Samuel Arthur Austin</b>			14. MOTHER'S MAIDEN NAME <b>Mary Chadwick Milnes</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I and II</b>			16. SOCIAL SECURITY NO.	17. INFORMANT <b>G. MILNES AUSTIN JR. WAYNESBORO VA</b>			ADDRESS
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Petty</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23B. DATE <b>5-11-1965</b>		23C. NAME of CEMETERY or CREMATORY <b>Riverview</b>		23D. LOCATION (City, town, or county) (State) <b>Waynesboro, Va.</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. J. [unclear]</b>		24C. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS <b>FOR ETTER F.H. WAYNESBORO VA</b>	

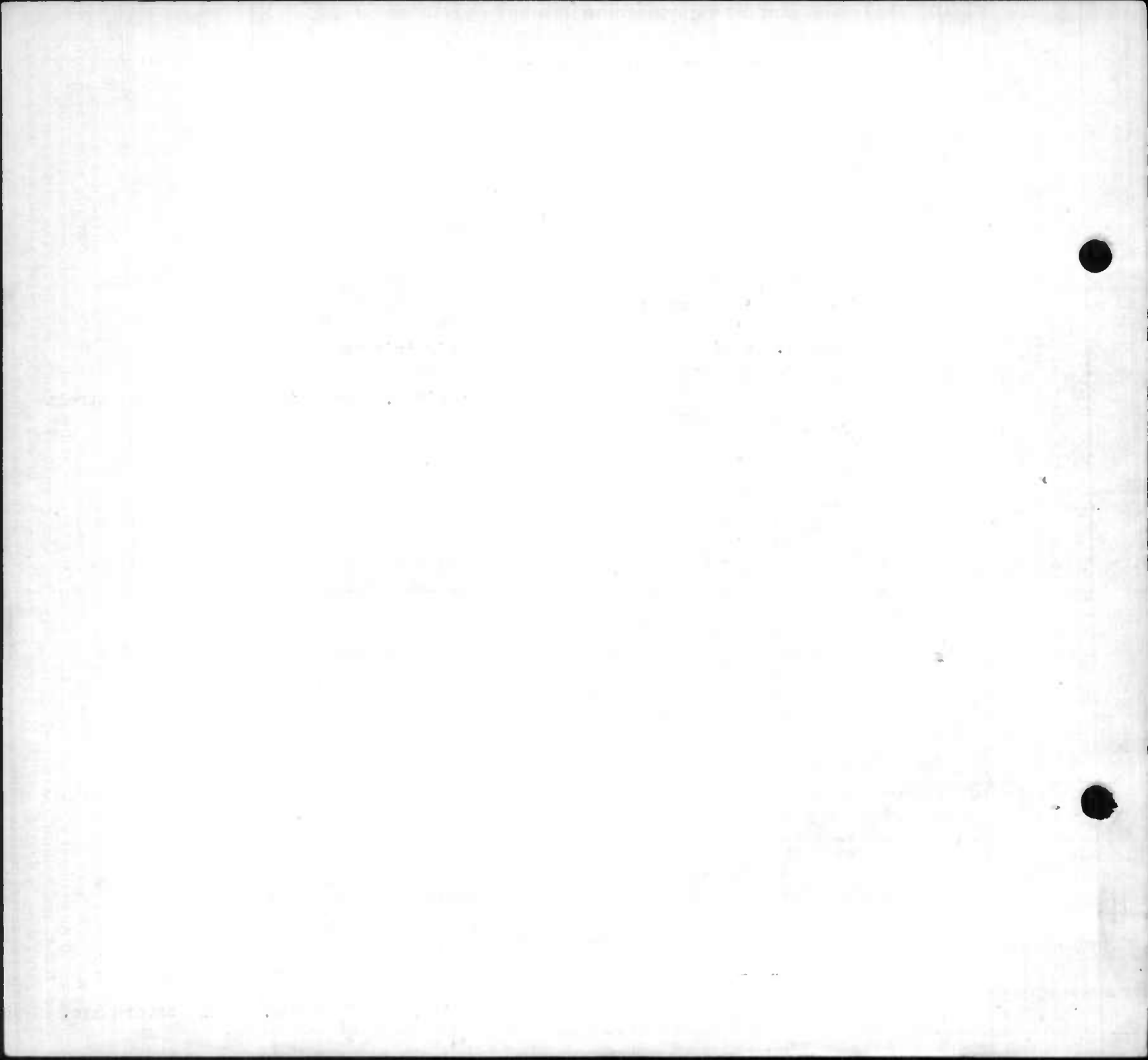
VALLEY BOULEVARD

1000 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

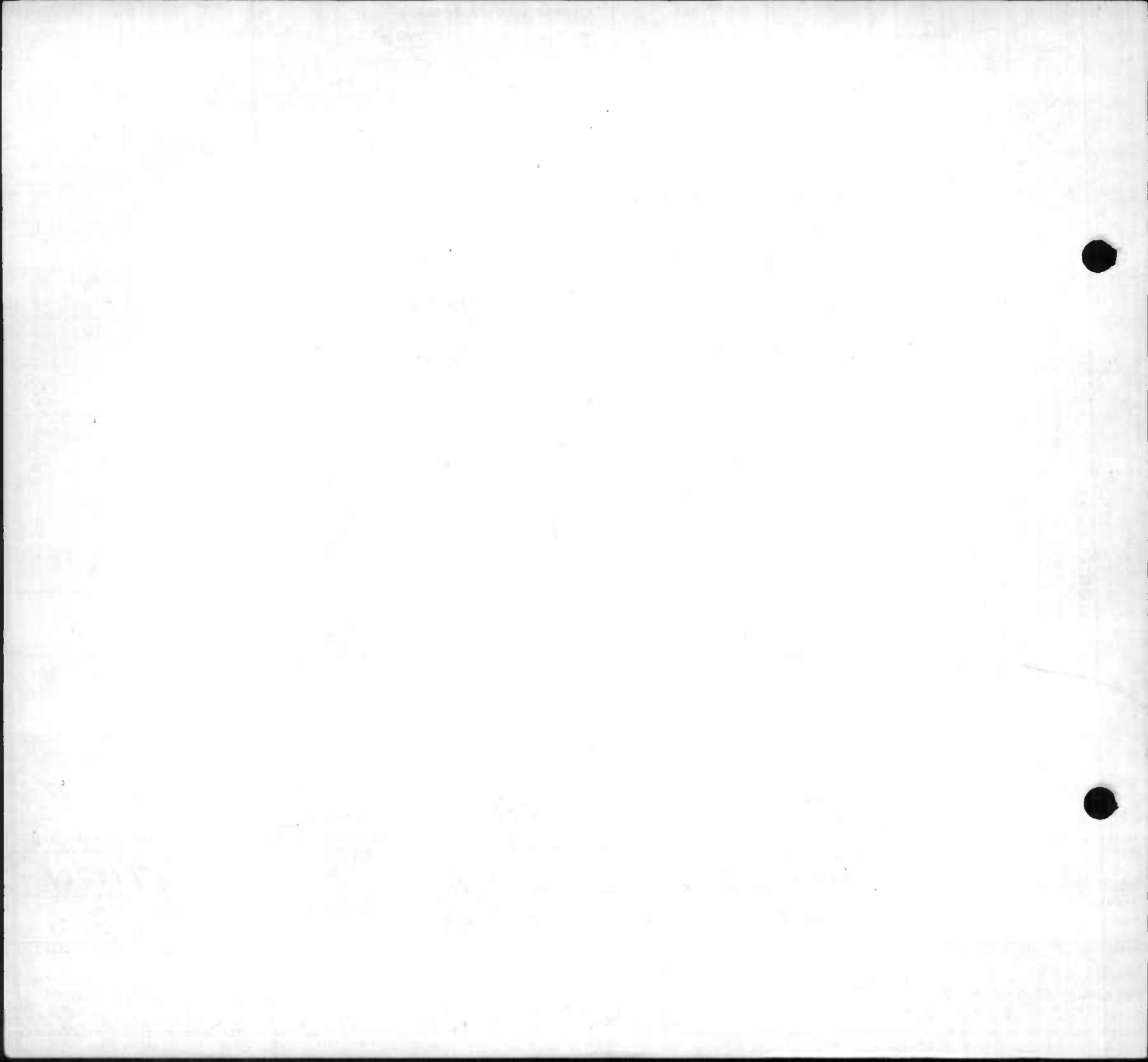
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4959</u>	
BIRTH NO. <u>65 4959</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>ETHEL VIRGINIA WAWRZYNIAK</u>		2. DATE AND HOUR OF DEATH <u>10 May 65</u> <u>8:30</u> A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		D. STREET ADDRESS (If rural, give location) <u>2208 Orleans St.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u>	8. DATE OF BIRTH <u>5/14/99</u>	9. AGE (In years last birthday) <u>65</u> <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>George W. Devall</u>		14. MOTHER'S MAIDEN NAME <u>Virginia May</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Francis M. Wawrzyniak 2208 Orleans Street</u>	
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>~ 6-8 hrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>cerebral vascular accident</u>		(B) <u>due to</u>		<u>18 days</u>	
(C) <u>Atherosclerotic cardio-vascular disease</u>		(C) <u>due to</u>		<u>year</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>she</u> (this hospital) attended the deceased from <u>22 April</u> 19 <u>65</u> to <u>10 May</u> 19 <u>65</u> , that <u>he</u> (we) last saw the deceased alive on <u>10 May</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard P. Norgaard</u> M.D.				23B. DATE SIGNED <u>10 May 65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard P. NORGAARD</u>				23D. ADDRESS <u>University Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-13-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memorial</u>	
				24D. LOCATION (City, town, or county) (State) <u>Cockeysville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Faller</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 4960					Registered No. 65 4960				
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>SAMUEL E. FONTE</b>					2. DATE AND HOUR OF DEATH <b>MAY 9, 1965 10 00 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CATONSVILLE 53-00</b> D. STREET ADDRESS (If rural, give location) <b>6013 BURNT OAK RD</b>				
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>					8. DATE OF BIRTH <b>10-22-1897</b> 9. AGE (In years lost birthday) <b>67</b>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>FOOD DEALER</b>				
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>LOUIS FONTE</b>					14. MOTHER'S MAIDEN NAME <b>VERA PORPORA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>216-05-0462</b>				
17. INFORMANT <b>SARAH FONTE</b>					ADDRESS <b>6013 BURNT OAK RD</b>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>443X1</b>					CAUSE OF DEATH (A) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (B) <b>10+ YRS</b> (C)				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
21A. DATE OF OPERATION					21B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>5/8</b> <b>1965</b> to <b>5/9</b> <b>1965</b> and that (I) (we) last saw the deceased alive on <b>5/8</b> <b>1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Thos E Roach</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <b>5/10/65</b>				
23C. PHYSICIAN'S NAME (Type) <b>THOS E ROACH</b> M.D.					23D. ADDRESS <b>5550 B&amp;O MARTINE B&amp;O 28</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					24B. DATE <b>5-13-1965</b>				
24C. NAME OF CEMETERY or CREMATORY <b>NEW CATHEDRAL CEM</b>					24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>					25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>				
25C. FUNERAL DIRECTOR ADDRESS <b>WEBER FUNERAL HOME 5314 EDMONDSON AVE</b>									

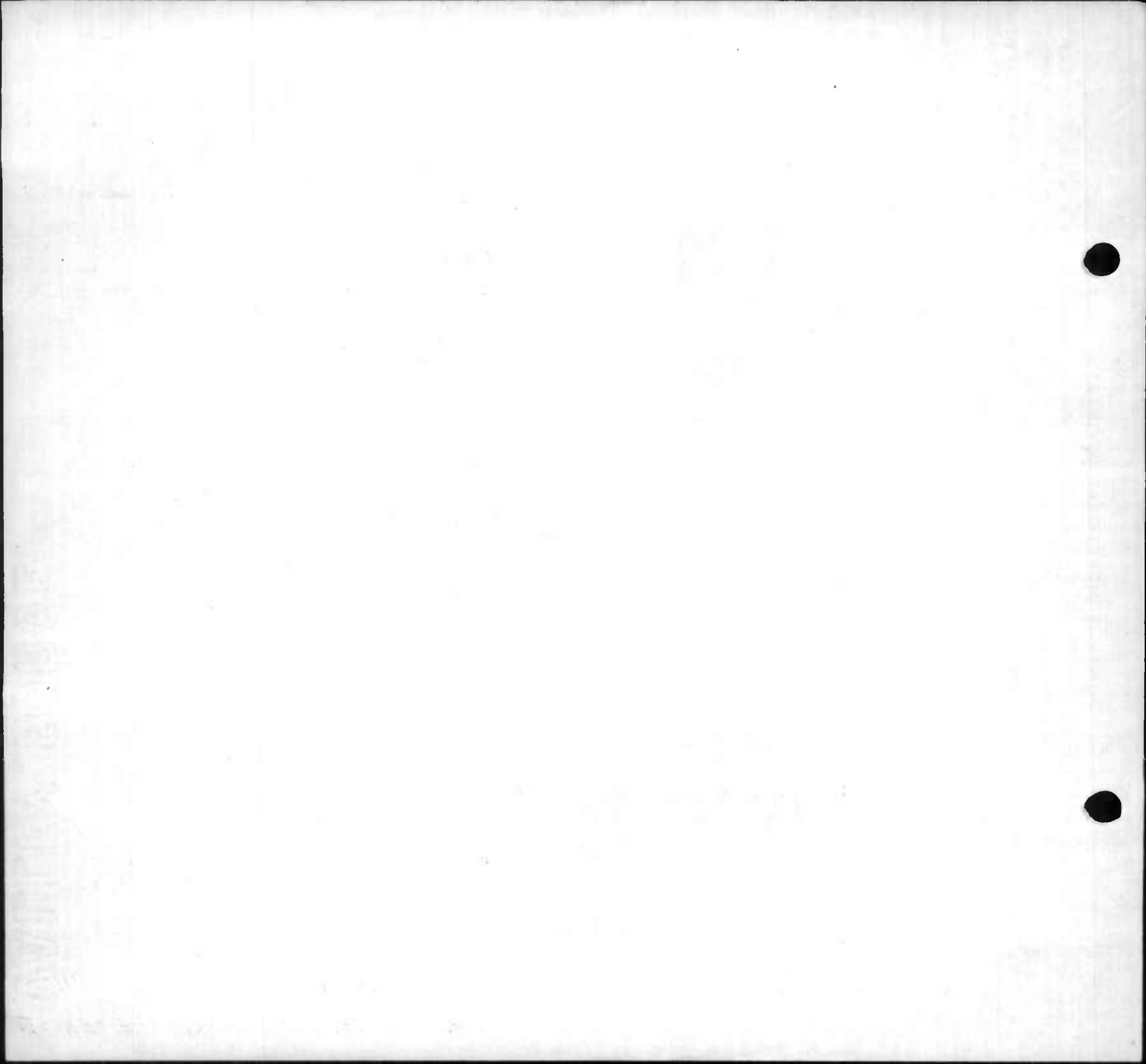




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. <span style="font-size: 1.2em;">65 4961</span> <span style="float: right;">4</span>	
BIRTH NO. <span style="font-size: 1.2em;">65-11098</span> <span style="font-size: 1.2em;">65 4961</span>							
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BABY BOY STEIGERWALD</span>				<span style="font-size: 1.2em;">MAY 9, 1965</span> <span style="font-size: 1.2em;">3:10 A.M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE</span>				A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">HOS</span>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE</span>			
D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">216 S. PATTERSON DR. AVE</span>							
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">SINGLE</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">5-8-65</span>	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">NONE</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">FREDERICK STEIGERWALD</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">JOAN KOWALSKI</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. <span style="font-size: 1.2em;">760.0 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <span style="font-size: 1.2em;">CNS BLEEDING?</span> (B) <span style="font-size: 1.2em;">MASSIVE ASPIRATION PNEUMONIA?</span> (C) <span style="font-size: 1.2em;">AGENESIS OF LUNGS?</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 hrs 10 mins</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">MAY 8</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">MAY 9</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 9</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Randy P. Benito, M.D.</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">5-9-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RANDY P. BENITO, M.D.</span>				23D. ADDRESS <span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTO, MD. 21215</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">5-10-1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">HOLY ROSARY CEM.</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">DUNDALK MD</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 11 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">JOHN M. WEBBERTSONS INC.</span>		ADDRESS <span style="font-size: 1.2em;">401 S. CHESTER ST.</span>	



1

65 1982

BALTIMORE CITY HEALTH DEPARTMENT

65 4962

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM Reid BALLARD

2. DATE AND HOUR PRONOUNCED DEAD

May 8, 1965

12:55 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 29

D. STREET ADDRESS (If rural, give location)

525 N. Nottingham Road

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Dec. 12, 1946

18 xx

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

McDonogh School

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Philip A. Ballard, Sr.

14. MOTHER'S MAIDEN NAME

Jean Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Philip A. Ballard, Sr., 525 Nottingham Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple Traumatic Injuries.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Gwynn Oak Ave., N. of Royal Oak Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
5 7 '65 P

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto into fixed object.

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/8/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

May 11/65

23C. NAME of CEMETERY or CREMATORY

Lorraine Park

23D. LOCATION

(City, town, or county)

Baltimore 7, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Witzke F.D. 4101 Edmondson Ave

ADDRESS

VALLEY FOLIO

PAID IN ADVANCE

1940

1940

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1940

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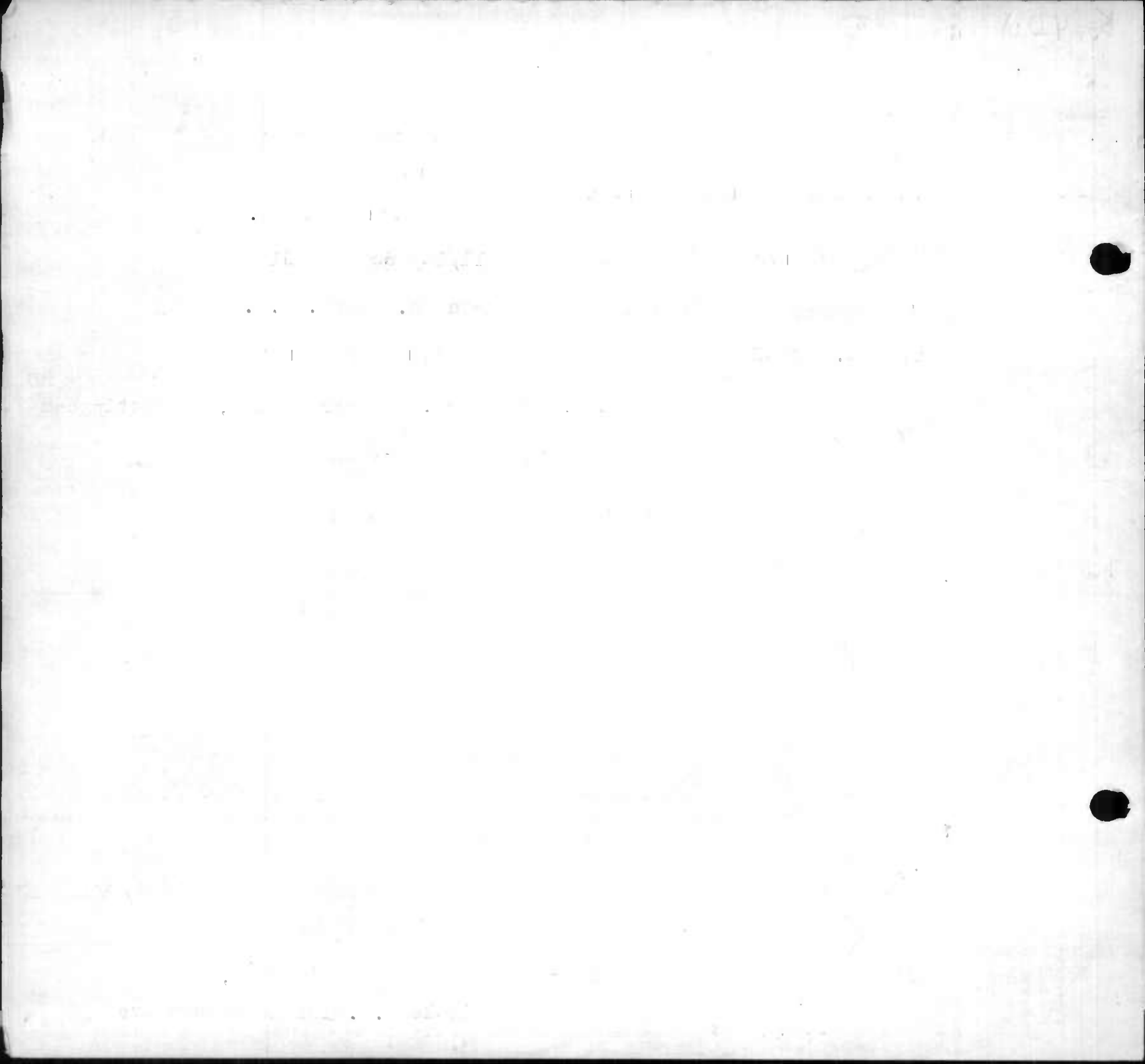
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed.

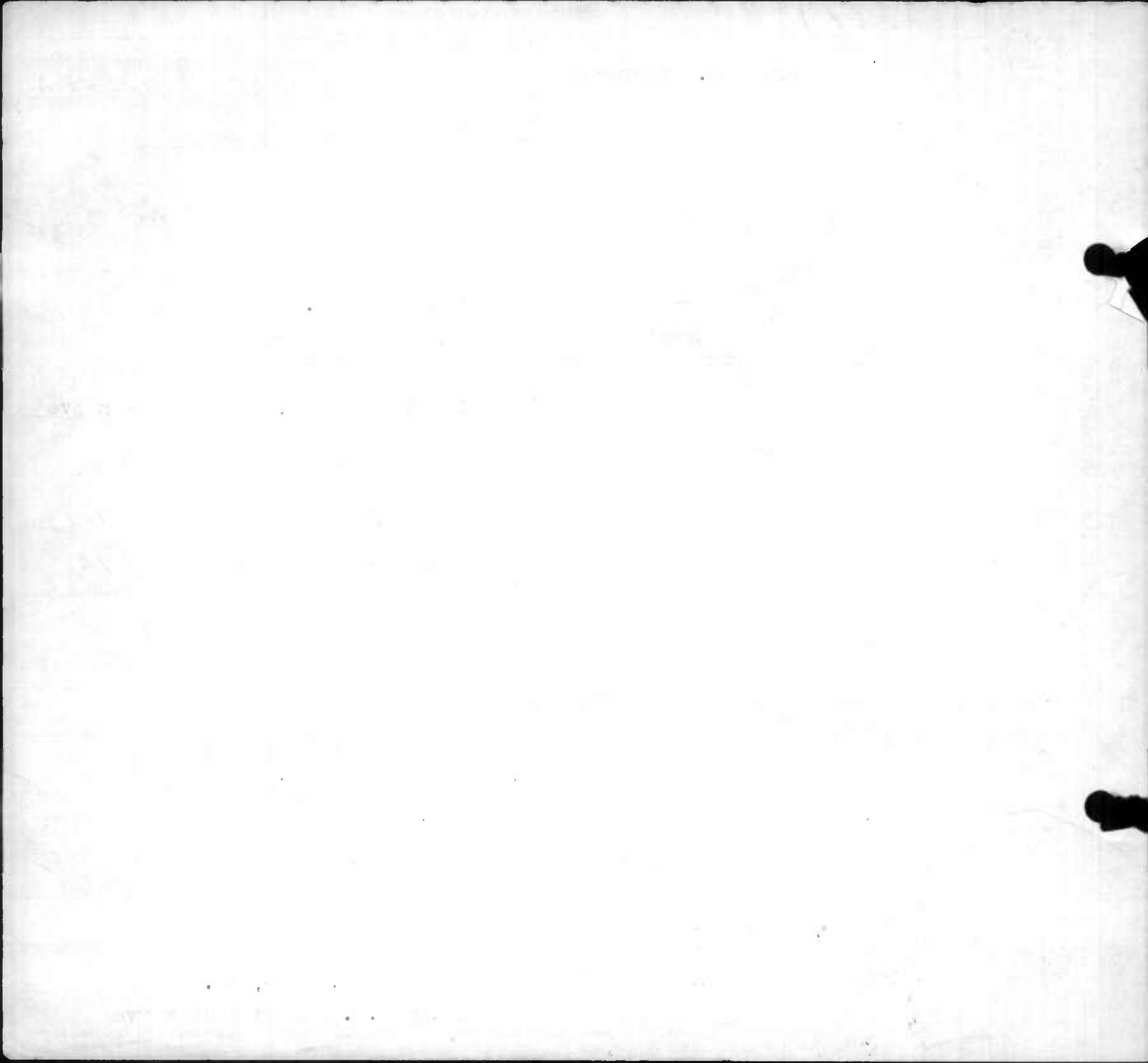
BALTIMORE CITY HEALTH DEPARTMENT				65 4963	
BIRTH NO. 65 4963				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No. 65 4963	
1. NAME OF DECEASED (Type or Print) <b>KELLY, OWEN W.</b>				2. DATE AND HOUR OF DEATH <b>5 8 65</b> <b>4 PM</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b> B. COUNTY <b>28-04</b>	
5. SEX <b>Male</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	
8. DATE OF BIRTH <b>11/12/63</b>		9. AGE (In years last birthday) <b>61</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ass't Manager</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel &amp; Wire Products Co. Wash.D .C.</b>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>WALTER G. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE KNEESSI</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212 03 1648</b>		17. INFORMANT ADDRESS <b>Mrs. Eleanor K elly, 503 Nottingham RD</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Questionable pulmonary embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>5/6</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Renal detachment</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> 19 <b>65</b> to <b>5/8</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>5/8</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walter R. Gilbert Jr.</b> M.D.				23B. DATE SIGNED <b>5/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>WALTER R. GILBERT JR. M.D.</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 11/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore 7, MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jakes</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D. 4101 Edmondson Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4964</u>	
BIRTH NO. <u>(6) 65 4964</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary D. LoGrande</u>		2. DATE AND HOUR OF DEATH <u>5-9-65</u> <u>12:50 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mersey Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 28</u> D. STREET ADDRESS (If rural, give location) <u>5834 Edmondson Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>8-28-05</u>	9. AGE (In years last birthday) <u>59</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
13. FATHER'S NAME <u>Salvatore Centineo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Fonti</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Dominick LoGrande, 5834 Edmondson Ave</u>	
18. <u>416 X + 1175.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <u>Central Venous Thrombosis</u>		<u>1 mon.</u>	
		(B) <u>Chronic Atrial Fibrillation</u>		<u>5 YR.</u>	
		(C) <u>Rheumatic Heart Disease &amp; mitral stenosis.</u>		<u>5 YR.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cranial Ca &amp; metastases</u>				<u>1 YR.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>110</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that <u>2</u> (this hospital) attended the deceased from <u>4-16-65</u> to <u>5-9-65</u> , that <u>2</u> (we) lost saw the deceased alive on <u>5-9-65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>2</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert L. Doyle</u> M.D.				23B. DATE SIGNED <u>5-9-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Robert L. Doyle</u>		23D. ADDRESS M.D. <u>Witzke F.D., 4101 Edmondson Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 12/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witzke F.D., 4101 Edmondson Ave</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4965	
BIRTH NO. 65 4965				CERTIFICATE OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William Baldwin		2. DATE AND HOUR OF DEATH 5-7-65 11:05 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-11		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21224	
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		D. STREET ADDRESS (If rural, give location) 620 S. East Ave.			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Sep.	8. DATE OF BIRTH 7-20-07	9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AMERICAN SUGAR		10B. KIND OF BUSINESS OR INDUSTRY Gen. Mech.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur Baldwin		14. MOTHER'S MAIDEN NAME Lillian Kimball Tittle	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 336-07-0447		17. INFORMANT ADDRESS Mrs. Lillian Tittle 620 S. East Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CA of Stomach		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4-28 1965 to 5-7 1965, that (we) last saw the deceased alive on 5-7 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. M. Kilchenstein		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-7-65	
23C. PHYSICIAN'S NAME (Type) Dr. M. Kilchenstein		23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/11/65		24C. NAME OF CEMETERY or CREMATORY OAK LAWN	
24D. LOCATION BALTO. CO. MD.		25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR G. W. Hoffmann		25D. ADDRESS 3218 HUDSON ST.			

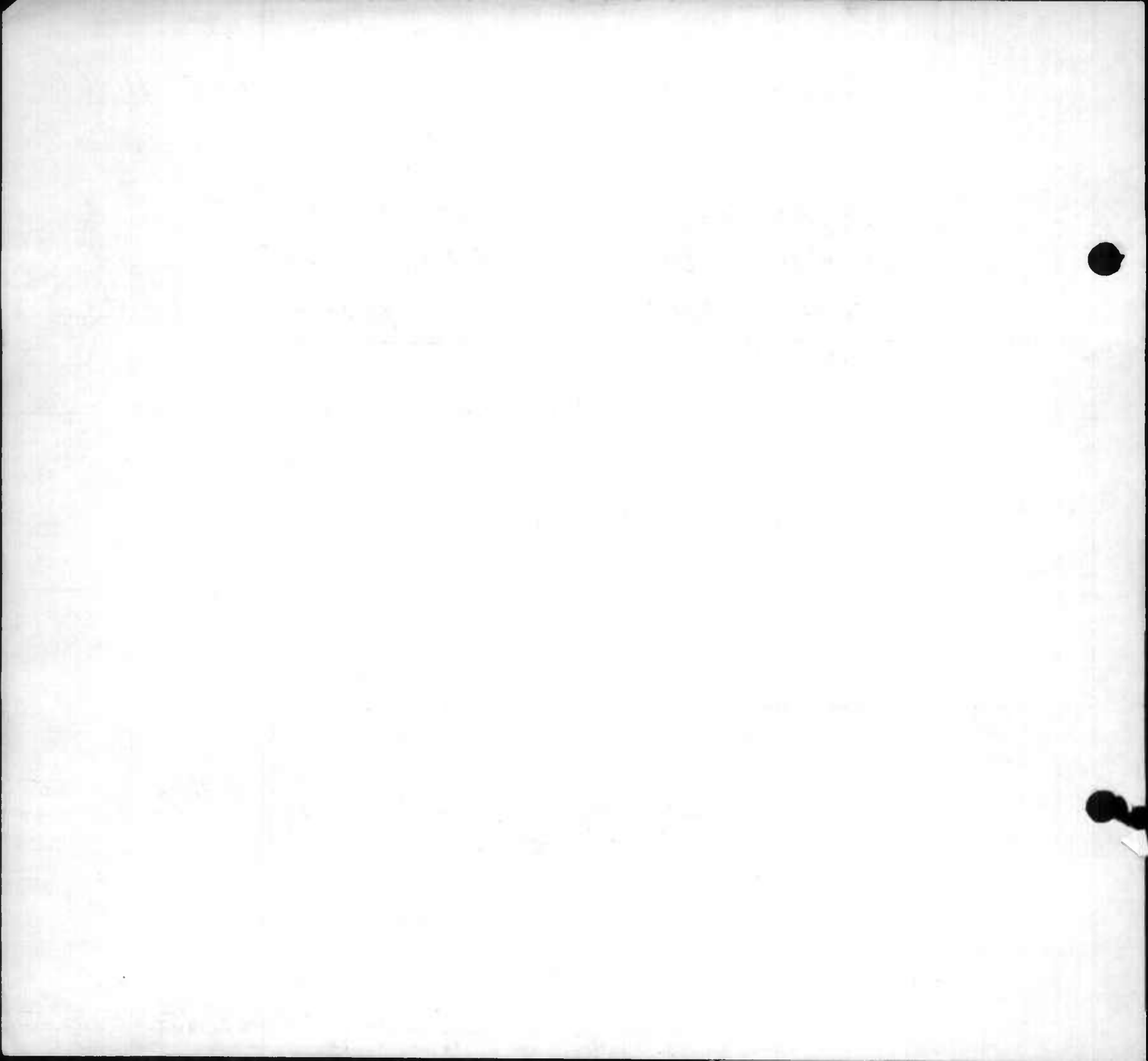
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

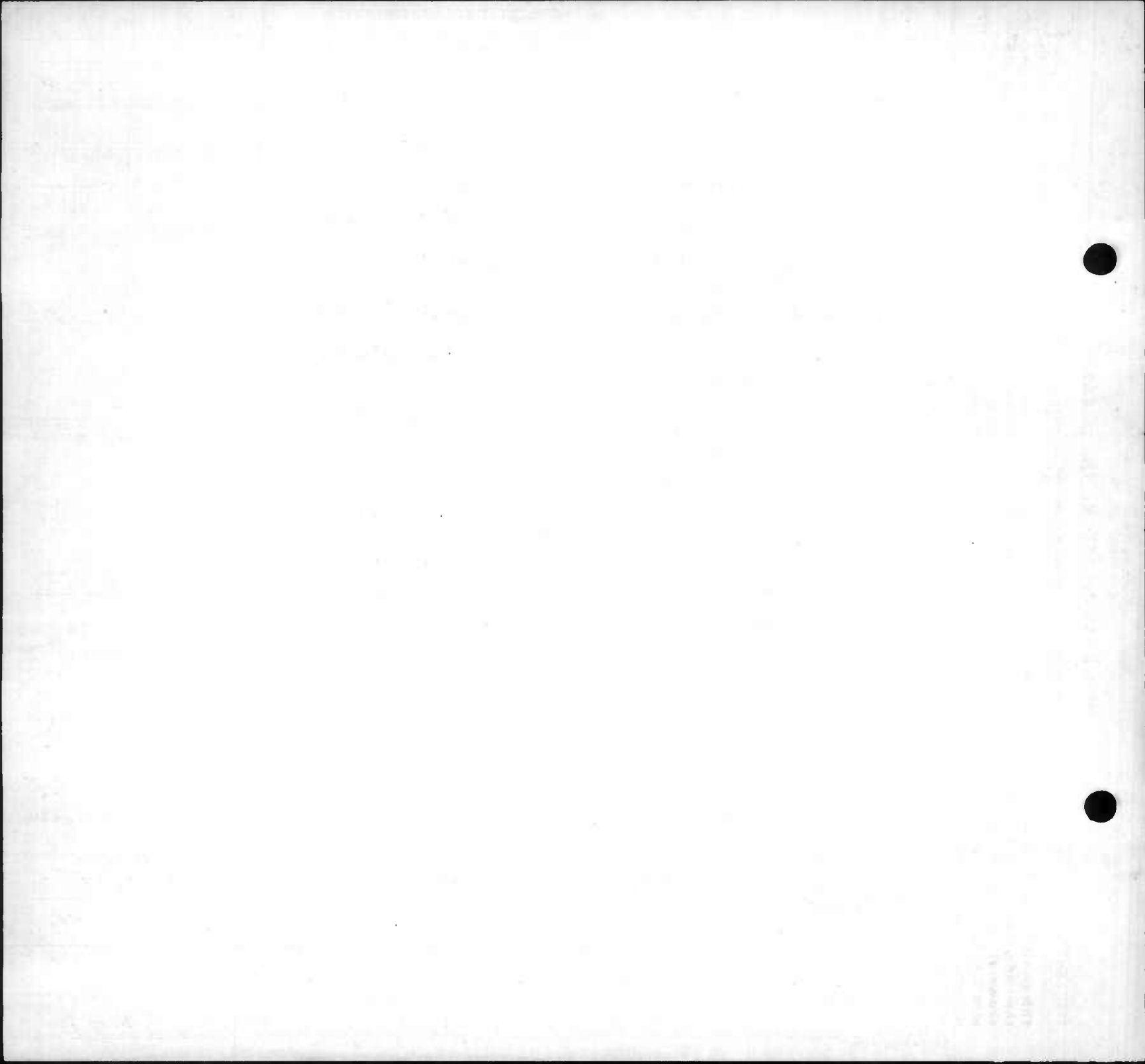
BIRTH NO. 65 4966				BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH				Registered No. 65 4966					
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <i>Fannie M. McCauley</i>				2. DATE AND HOUR OF DEATH <i>May 8, 1965 11:45 A.M.</i>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>19-04</i>									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>303 S. Monroe St.</i>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>				D. STREET ADDRESS (If rural, give location) <i>303 S. Monroe St.</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i>	8. DATE OF BIRTH <i>Nov. 11, 1899</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Shirt Factory</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>217-09-2603</i>		17. INFORMANT <i>Marie Walters Pratt + Stricker Sts</i>				ADDRESS			
18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Ac Cerebral Occlusion</i> DUE TO (B) <i>Arteriosclerosis Cerebri</i> DUE TO (C) _____				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 yos</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
19A. DATE OF OPERATION <i>5/4</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>1965</i> to <i>5/8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5/4</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <i>E. S. Hallen</i>								M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/8/65</i>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. <i>4300 Liberty Hts Dr</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>8/11/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Vincent De Paul Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1965</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>				25C. FUNERAL DIRECTOR <i>Walter Funeral Home Pratt + Stricker Sts</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

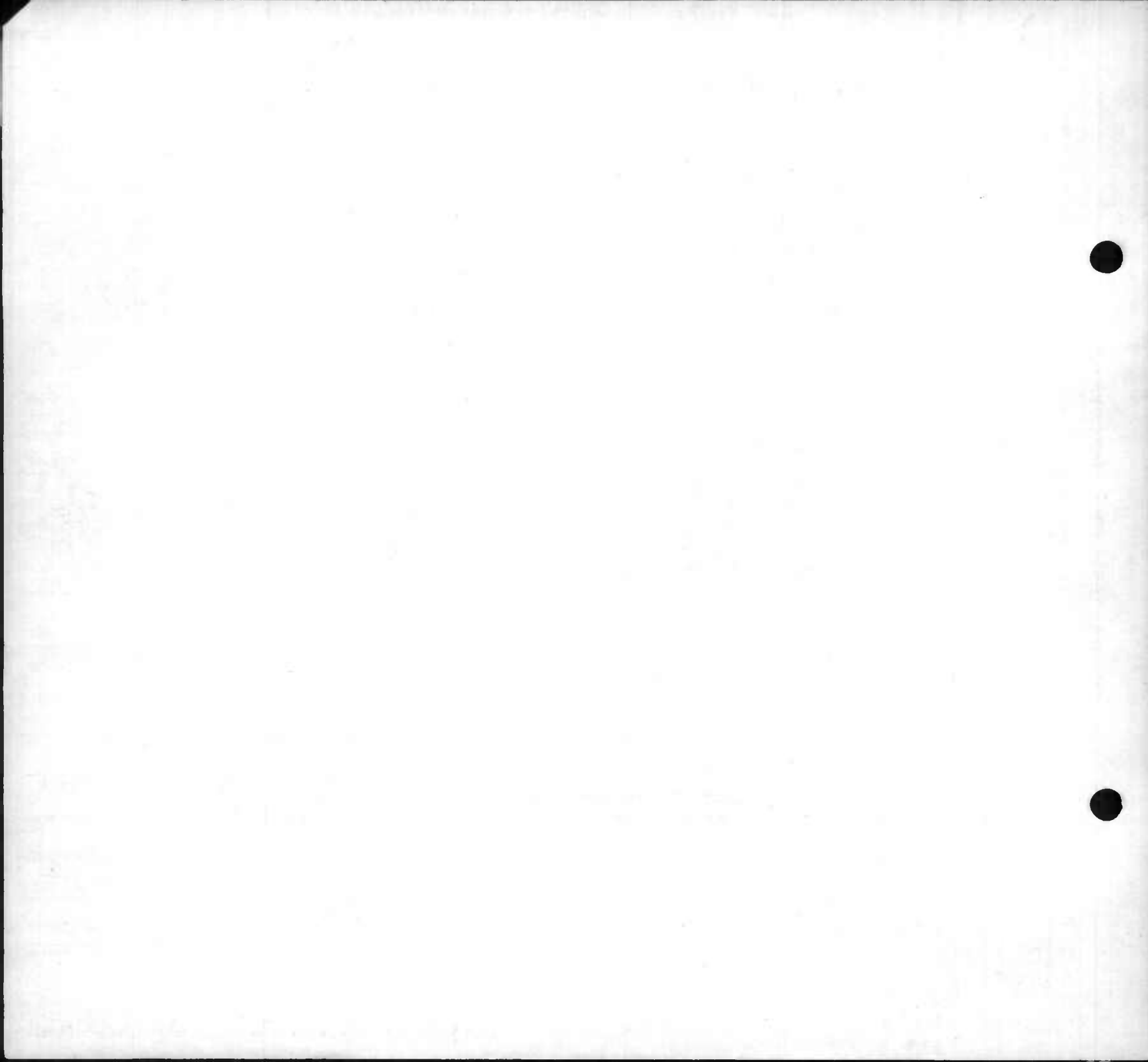
BIRTH NO. 65 4967		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4967	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) James E. Durham				May 9 1965 9.45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6433 Danville Ave				A. STATE Maryland B. COUNTY 26-36	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore	
				D. STREET ADDRESS (If rural, give location) 6433 Danville Ave	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 12-3-1906	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Keeper		10B. KIND OF BUSINESS OR INDUSTRY Edgewood Arsenal		11. BIRTHPLACE (State or foreign country) Cambridge, Md.	
13. FATHER'S NAME Janes E. Durham			14. MOTHER'S MAIDEN NAME Sara Larrimore		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 2I4078479		17. INFORMANT ADDRESS Mary Durham 6433 Danville Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) H-S-C-U-Disease DUE TO Emphysema, Advanced (B) CA P. Prostate G. Metastasis to Abdomen INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs 8 mos	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 1964 to May 9 1965, that (I) (we) last saw the deceased alive on May 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.B. Davis MD				23B. DATE SIGNED 5/10/65	
23C. PHYSICIAN'S NAME (Type) M.B. Davis MD				23D. ADDRESS M.D. 6800 MOKWINGTH RW - DUNDALK 21222	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-13-65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Of Jesus	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Kathleen [Signature] 1005 Dundalk Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4968		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4968	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BISHOP KATHERINE CANTWELL		2. DATE AND HOUR OF DEATH May - 6 <sup>th</sup> 1965 10 <sup>37</sup> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Balt.			
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE 5300			
		D. STREET ADDRESS (If rural, give location) 5, RIDGE RD			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 1-5-01	9. AGE (In years, last birthday) 64	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OWEN J. CANTWELL			14. MOTHER'S MAIDEN NAME KATHERINE CHAMBERS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS GEORGE BISHOP husband - SAME		
18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO CARCINOMA of RECTUM & LIVER METASTASIS (B) DUE TO UREMIA DUE TO RENAL FAILURE (C) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 4/20/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA Rectum + L.O.		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-16-65 to 5-6-65, that (I) (we) last saw the deceased alive on 5-6-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francisco M. Sandoval				23B. DATE SIGNED 5/6/65	
23C. PHYSICIAN'S NAME (Type) FRANCISCO M. SANDOVAL		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/10/65		24C. NAME OF CEMETERY or CREMATORY CATHEDRAL	
24D. LOCATION (City, town, or county) (State) BALTO. MD		25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR R. M. M. M. M.		25D. ADDRESS 301 FREDERICK RD			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

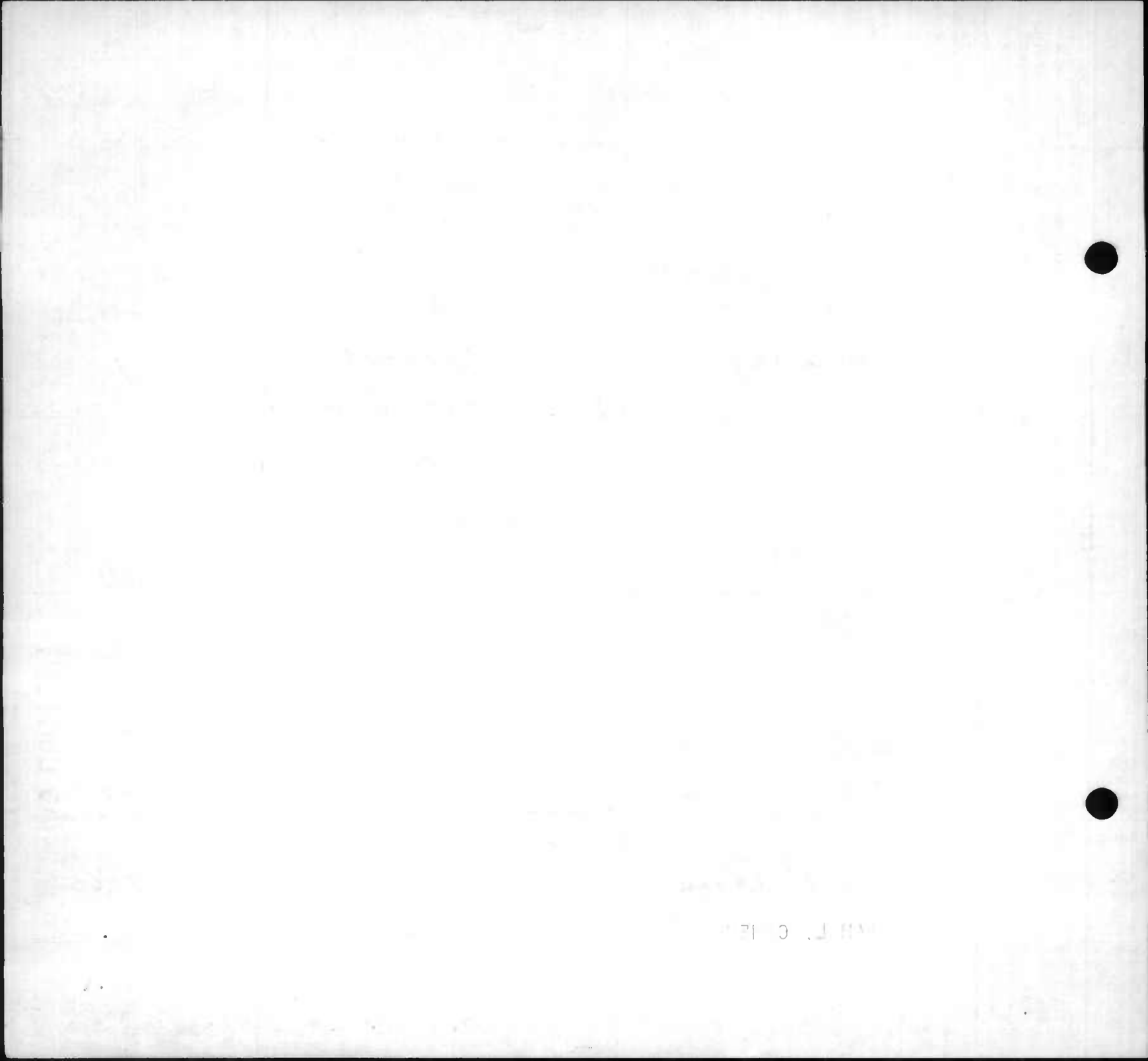
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 4969</span>				
BIRTH NO. <span style="font-size: 1.2em;">65 4969</span>					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) <i>George H. Gillespie</i>					2. DATE AND HOUR OF DEATH <i>May 6, 1965 9:55 P.M.</i>				
3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>St. Joseph's Hosp. D.O.A.</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pardale</i>				
					D. STREET ADDRESS (If rural, give location) <i>6116 Everall Ave.</i>				
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>3/27/83</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Ooys		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Wm. F. Gillespie</i>					14. MOTHER'S MAIDEN NAME <i>Anna Campbell</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>212-01-9203</i>		17. INFORMANT ADDRESS <i>Son (Same as above)</i>				
18. <span style="font-size: 1.2em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) DUE TO <i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>		
					(B) DUE TO <i>Coronary thrombosis</i>		<i>"</i>		
					(C) DUE TO <i>Arteriosclerotic Cardiovascular disease</i>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pulmonary Emphysema</i>									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>June 1964</i> to <i>May 5 1965</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>May 5 1965</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <i>Paul G. Mueller</i>					M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>5/10/65</i>		
23C. PHYSICIAN'S NAME (Type) <i>Paul G. Mueller</i>					23D. ADDRESS <i>6411 Belair Rd Baltimore Md.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/10/65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Co. Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Connelly</i>		ADDRESS <i>300 Mace Ave. Balto. 21</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4970				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4970	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Anna m. Heaps</i>				2. DATE AND HOUR OF DEATH <i>5/9/65 - 11:45 PM.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>				A. STATE <i>Maryland</i> B. COUNTY <i>13-06</i>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>711 W. 34th Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i>	8. DATE OF BIRTH <i>2-25-76</i>	9. AGE (In years last birthday) <i>89</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Iley</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Stansbury</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-071869</i>		17. INFORMANT <i>Son - Earl Heaps - Some</i>	
18. <i>443X I</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) <i>Right cerebral Hemorrhage</i>		<i>3 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Hypertensive &amp; arteriosclerotic</i>		<i>cardio vascular disease</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(C)			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-7-19-65</i> to <i>5-9-19-65</i> that (I) (we) last saw the deceased alive on <i>5-9-19-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Miriam L. Cohen</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-9-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MIRIAM L. COHEN</i>				23D. ADDRESS <i>Union Memorial Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-13-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>BELAIR MEM GROENS</i>		24D. LOCATION (City, town, or county) (State) <i>BELAIR MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Paul E. Schaefer</i>		ADDRESS <i>3615</i>	



LS: 42-69-24 1

65 4971

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 4971

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Jacob Dumeier Sr.

2. DATE AND HOUR OF DEATH

May 9, 1965

10:00 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hosptials  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

RURAL:

D. STREET ADDRESS (If rural, give location)

514 Riverside Road #21221

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Widowed

8. DATE OF BIRTH

12-4-83

9. AGE (In years  
last birthday)

81

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Ret.

10B. KIND OF BUSINESS OR INDUSTRY

Cement Finisher

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Jacob Dumeier

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

217-07-1121

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 177X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) Cerebral Vascular Accident  
DUE TO(B) Metastatic Carcinoma  
DUE TO

(C) Carcinoma of Prostate

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Cardiovascular Disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from January 25, 19 65 to May 9, 19 65,  
that (I) (we) last saw the deceased alive on May 9, 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 9, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-12-1965

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION

(City, town, or county)

Baltimore Co.

Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

25B. NAME OF REGISTRAR

Robert E. Farley

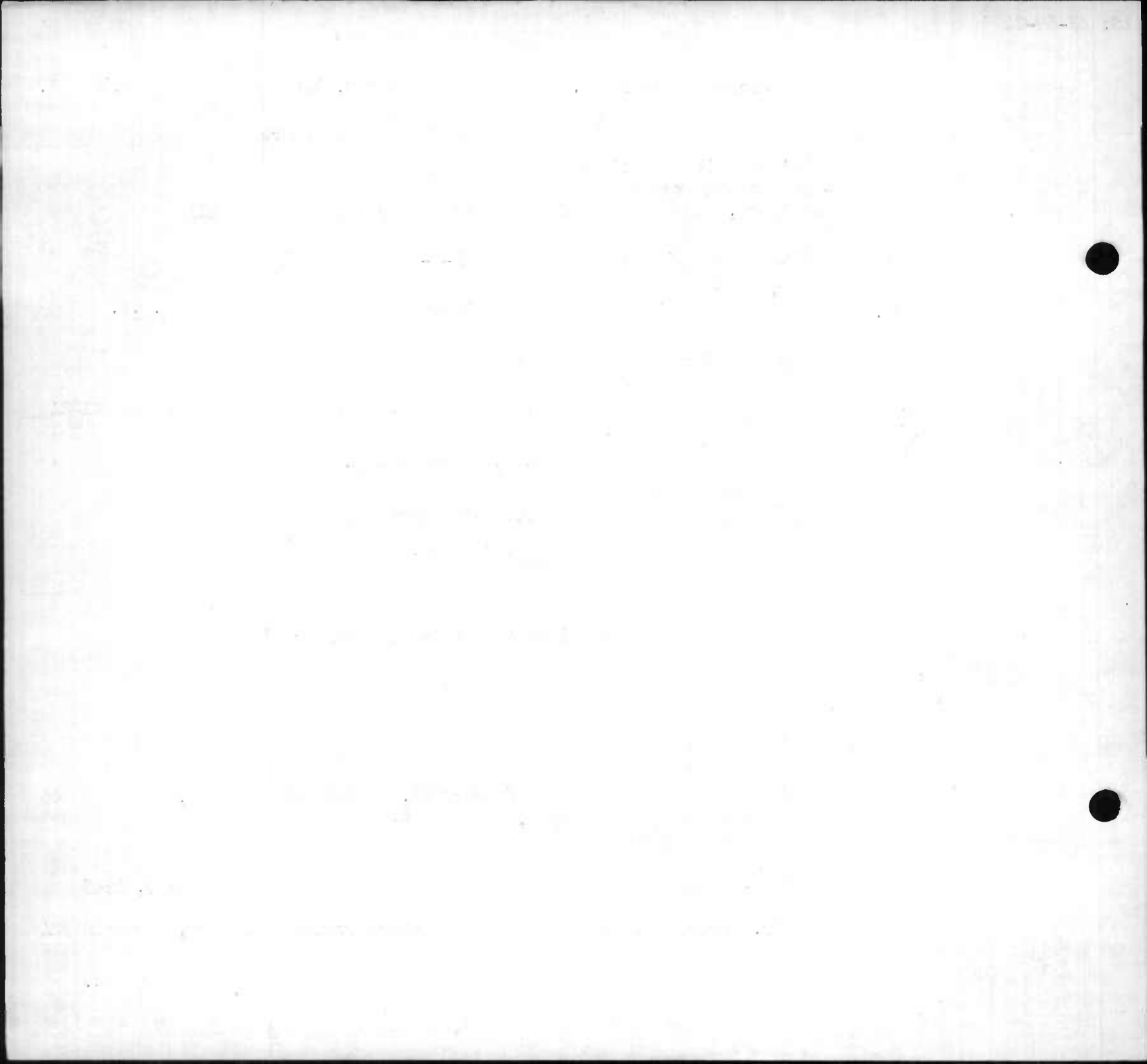
25C. FUNERAL DIRECTOR

The Baltimore Funeral Home 7401 Belair Road

ADDRESS 36

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**CERTIFICATE CORRECTED 5-20-65**

**BIRTH NO.** 65 4972 **CITY HEALTH DEPT.** **CERTIFICATE OF DEATH** **Registered No.** 65 4972

**M.E. CASE NO.** **1. NAME OF DECEASED** (Type or Print) **DIXON, CHARLES WILLIAM** **2. DATE AND HOUR OF DEATH** 5/8/65 11:50 A.M.

**3. PLACE OF DEATH IN BALTIMORE, MARYLAND** **4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
**A. STATE** MD. **B. COUNTY** 21-02

**5. SEX** M **6. RACE** White **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)** MARRIED **8. DATE OF BIRTH** 11/4/10 1911 **9. AGE** (In years last birthday) 54-53 **10. A. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) PRODUCTION MANAGER **10B. KIND OF BUSINESS OR INDUSTRY** SHOE MANUFACTURING COMPANY **11. BIRTHPLACE** (State or foreign country) MD **12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME** JOSEPH DIXON **14. MOTHER'S MAIDEN NAME** ETHEL SHECKLES

**15. Was Deceased Ever in U. S. Armed Forces?** (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN **16. SOCIAL SECURITY NO.** UNKNOWN **17. INFORMANT** CHART **ADDRESS** UNIVERSITY HOSP.

**18. CAUSE OF DEATH**  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**ANTecedent CAUSES**  
 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  
 (A) METASTATIC NEOPLASM OF BRAIN  
 (B) NEOPLASM of Lung  
 (C) \_\_\_\_\_

**II**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** 2 NONE **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** \_\_\_\_\_ **20A. AUTOPSY?** (Yes or No) YES **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** \_\_\_\_\_

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (notify medical examiner) ☐ **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location) \_\_\_\_\_

**21D. TIME OF INJURY** (Month) (Day) (Year) (Hour) (APPROX.) \_\_\_\_\_ **21E. INJURY OCCURRED** While At Work ☐ Net While At Work ☐ **21F. HOW DID INJURY OCCUR?** \_\_\_\_\_

**22. I certify that (I) (this hospital) attended the deceased from** 4/9/65 19 to 5/8/65 19, that (I) (we) last saw the deceased alive on 10 AM 5/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

**23A. SIGNATURE** *Brandon L. W. Adams* M.D. **23B. DATE SIGNED** 5/8/65

**23C. PHYSICIAN'S NAME (Type)** BRANDON L. W. ADAMS M.D. **23D. ADDRESS** 1365 First Ave; Bldg. 13, MD.

**24A. BURIAL CREMATION, REMOVAL (Specify)** Burial **24B. DATE** 5/12/65 **24C. NAME OF CEMETERY OR CREMATORY** London Park Cemetery **24D. LOCATION** (City, town, or county) (State) 3901 Frederick Ave

**25A. DATE REC'D BY HEALTH/DEPT.** MAY 11 1965 **25B. NAME OF REGISTRAR** Robert E. [Signature] **25C. FUNERAL DIRECTOR** [Signature] **ADDRESS** 23rd St. 23rd Md.

VS 150-REV. 1/1/65

V.S. 153

5-20-65

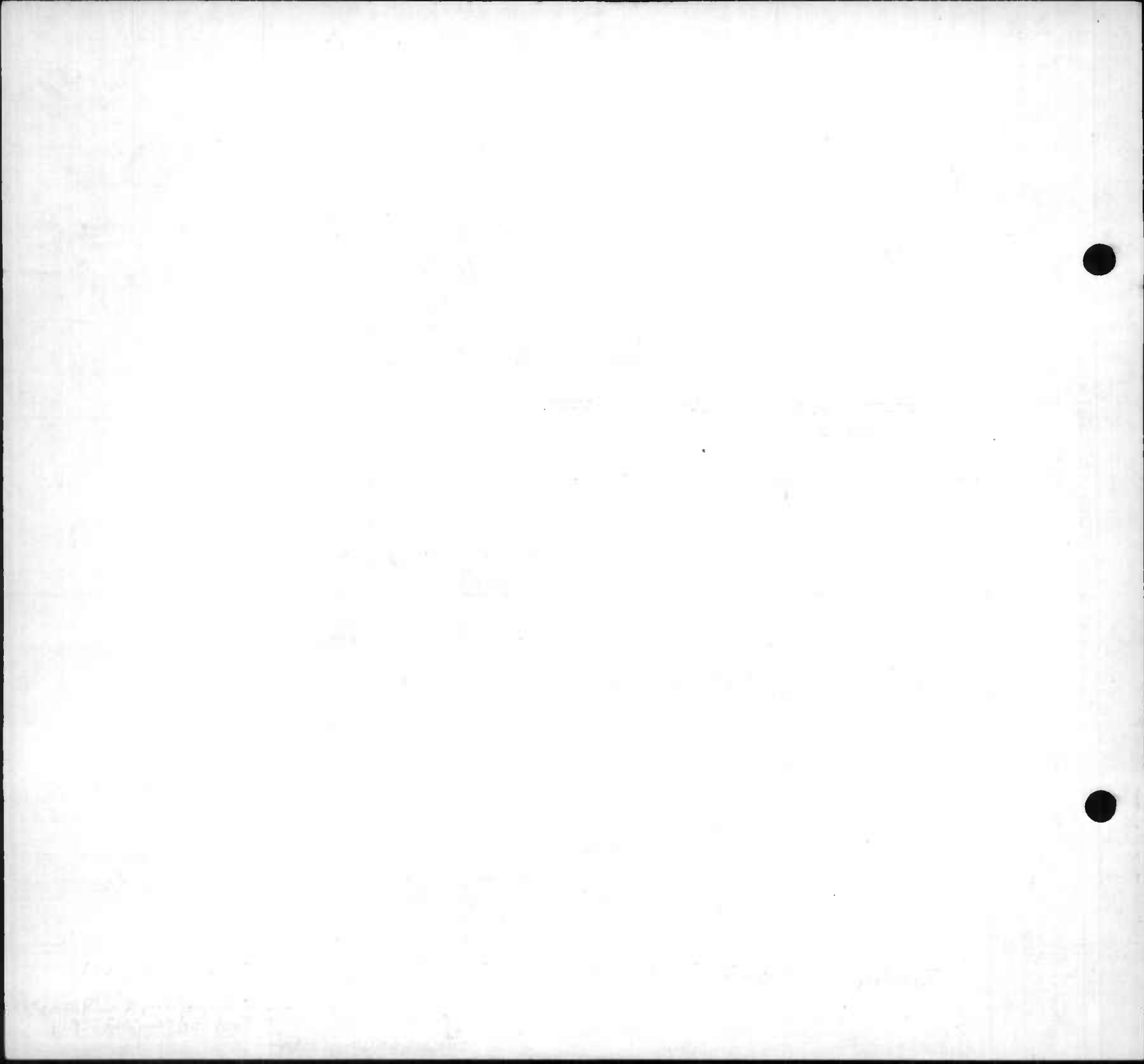
M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

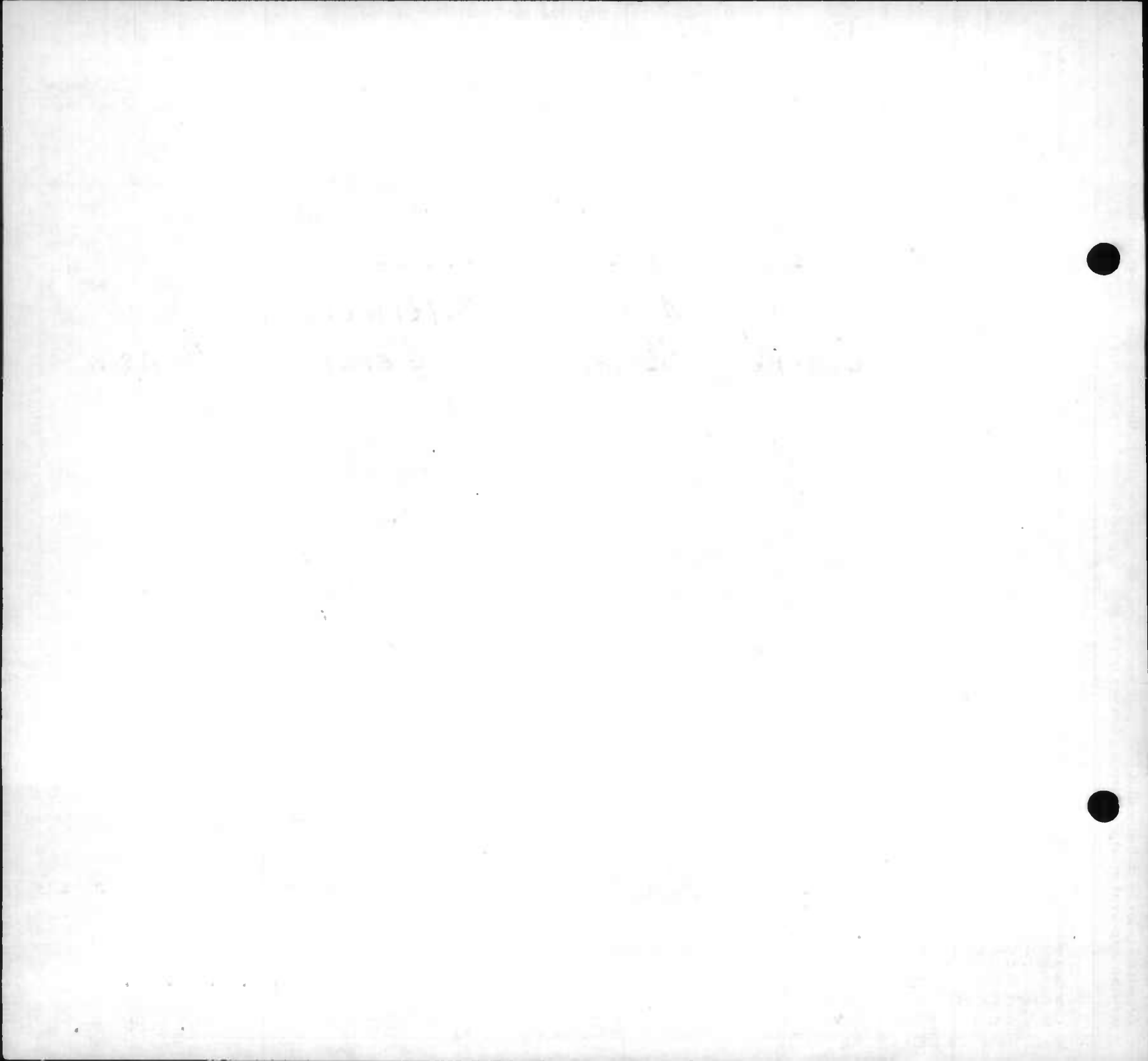
BIRTH NO. 65 4973				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4973	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>COALE, JOSEPH LEROY</b>				2. DATE AND HOUR OF DEATH <b>5/8/65 10 50 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>				A. STATE <b>MD</b> B. COUNTY <b>Hartford</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BEL AIR 6732</b>			
D. STREET ADDRESS (If rural, give location) <b>20 EASTERN AVE.</b>							
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>1/7/96</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARTS MANAGER - RET.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AUTO REPAIR</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOSEPH COALE</b>				14. MOTHER'S MAIDEN NAME <b>GEORGIE ERHARDT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>218-32-1502</b>		17. INFORMANT <b>UMH CHART</b>	
18. <b>420.14181.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>PULMONARY EDEMA</b>				DUE TO		<b>2 DAYS</b>	
DUE TO				<b>ASCVD &amp; POSSIBLE MYOCARDIAL INFARCTION</b>		<b>UNK</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CARCINOMA OF BLADDER - ? METASTASES</b>						<b>1 YR</b>	
19A. DATE OF OPERATION <b>1/4/15/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA OF BLADDER</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? <b>-</b>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>-</b>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>5/7/1965</b> to <b>5/8/1965</b> , that (I) (we) last saw the deceased alive on <b>5/8/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>EXR</b>							
23A. SIGNATURE <b>D. David Beyson</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>D. David Beyson</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>May 11, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Bel Air Memorial Gardens</b>		24D. LOCATION (City, town, or county) (State) <b>Bel Air, Hartford Co., Maryland</b>	
25A. DATE REG'D BY HEALTH DEPT. <b>MAY 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Joseph William Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4974	
BIRTH NO. 65-10906				65 4974	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Baby Girl Stump "A"		5-10-65 1:45 A.M.	
3. PLACE OF DEATH IN BALTIMORE MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
		A. STATE Maryland.		B. COUNTY 23-01	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
South Baltimore General Hosp.		Baltimore #21230.			
D. STREET ADDRESS (If rural, give location)		1250 Sharp St.			
5. SEX F	6. RACE W.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N.B.	8. DATE OF BIRTH 5-8-65	9. AGE (In years last birthday) N.B.	10. If Under 1 Yr. Months: Days: Hours: Min. 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		None.		Baltimore, Md.	
13. FATHER'S NAME Joseph Stump			14. MOTHER'S MAIDEN NAME Geraldine Benson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO.		17. INFORMANT Family
					Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 262.51		CAUSE OF DEATH (A) DUE TO Respiratory distress (Helaefasci) (B) DUE TO Prematurity (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from 5-8-1965 to 5-10-1965, that <del>the</del> (we) last saw the deceased alive on 5-10-1965 and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earlie Francis				23B. DATE SIGNED 5-10-65	
23C. PHYSICIAN'S NAME (Type) Dr. Earlie Francis				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5 11 65		24C. NAME OF CEMETERY or CREMATORY Holy Cross	
				24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR R. E. Fisher		25C. FUNERAL DIRECTOR McGully	
				ADDRESS 130 E. Fort Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4975		BALTIMORE CITY HEALTH DEPT.		CERTIFICATE OF DEATH		Registered No. 65 4975	
1. NAME OF DECEASED (Type or Print) <b>FORREST, MRS. ALVERTA E.</b>				2. DATE AND HOUR OF DEATH <b>May 9, 1965 3:50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>7-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 5</b> D. STREET ADDRESS (If rural, give location) <b>2427 McElderry St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>	8. DATE OF BIRTH <b>8-10-99</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Barrows</b>				14. MOTHER'S MAIDEN NAME <b>Anna Schlosser</b>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-5830</b>		17. INFORMANT <b>Frank Forrest - 2427 McElderry</b>			
18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Competitive Heart Failure weeks</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease years</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1965</b> to <b>May 9, 1965</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>May 9, 1965</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> view the body after death.							
23A. SIGNATURE <b>Cesar R. Bariso</b> M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/9/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR R. BARISO</b> M.D.				23D. ADDRESS <b>Church Home &amp; Hospital - Balto. 31, Ind.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/13/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3531 Brenna Lane #13</b>	

50235 700 4 1967 3-2805

See the table of  
the 1967

See the table of 1967

Female White 2-10-19  
transcript  
Henry Brown  
Frank Brown - 2472  
from

Inspector (see table)  
Cottrell & Brown

he

May 4, 1967  
April 3, 62 May 4, 62  
2/1/62  
Cesar E. Barrio  
Gen. F. Brown

BIRTH NO.

65

4976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BETTY LEE KIFFER

2. DATE AND HOUR PRONOUNCED DEAD

May 8, 1965

12:05A<sub>M.</sub>

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1030 N. Calvert Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

separated

8. DATE OF BIRTH

4/8/26

9. AGE (In years  
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Gay White Way

11. BIRTHPLACE (State or foreign country)

Yarrowsburg, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ernest Carter

14. MOTHER'S MAIDEN NAME

Lillian Redmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT 5178 Wright Ave. ADDRESS Zone 5  
Ernest Carter, Jr., Brother

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Acute Ethylism.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
5/8/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/10/65

23C. NAME of CEMETERY or CREMATORY

Brownsville Cem.

23D. LOCATION

(City, town, or county)

(State)

Washington County, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.  
3331 Brehms Lane

MAY 11 1965

WALTON PRODUCE

Robert L. Lister

W. L. Lister

W. L. Lister

William Lister

W. L. Lister  
W. L. Lister  
W. L. Lister

W. L. Lister

W. L. Lister

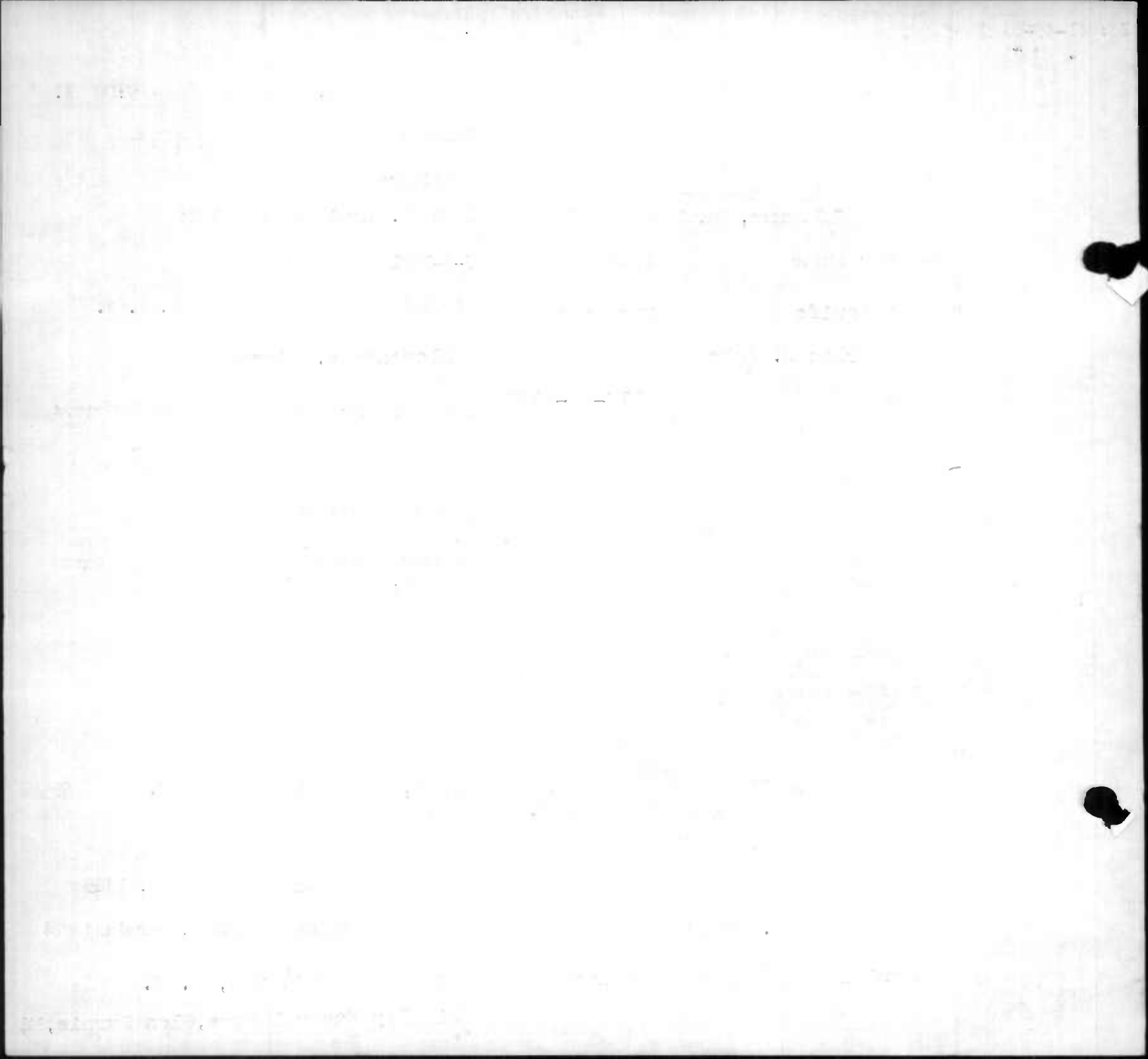


LS: 41-45-00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4977				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 4977	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Florence Cummings						May 7, 1965		9:00 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Maryland		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224				1520 Mt. Royal Avenue #21224		D. STREET ADDRESS (If rural, give location)			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Female	White	Divorced	3-5-1891	74	Housewife	Own Home	Virginia	U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Charles R. Lake				Florence V. Rixey					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				219-28-2127		RECORDS: BCH: 4940 Eastern Avenue #21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) Cardiac Arrest				Minutes	
ANTECEDENT CAUSES				(B) Atrial Fibrillation				Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) Arteriosclerotic Cardiovascular Disease, Diabetes				Years	
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from August 31, 1964 to May 7, 1965, that (I) (we) last saw the deceased alive on May 7, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
Dr. Howard Rathbun						May 7, 1965			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Dr. Howard Rathbun				M.D. 4940 Eastern Avenue Baltimore, Maryland #24					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		5/10/65		Glenwood Cemetery		Washington, D. C.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
MAY 11 1965				Robert E. Taylor		Kirkley Funeral Home, Glen Burnie, Md			



1  
F-122

BIRTH NO. 65 4978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **BERNARD F. FABISZAK** 2. DATE AND HOUR PRONOUNCED DEAD **May 8, 1965 9:27 P** M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY \_\_\_\_\_

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Church Home and Hospital** C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 6-01

D. STREET ADDRESS (If rural, give location) **12 N. Potomac Street**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Married** 8. DATE OF BIRTH **8/11/1905** 9. AGE (In years, lost birthday) **59** If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Tailor** 10B. KIND OF BUSINESS OR INDUSTRY **Clothing Mfg.** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Andrew Fabiszak** 14. MOTHER'S MAIDEN NAME **Petronella Dziennik**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **216-07-4279** 17. INFORMANT **Mrs. Margaret Fabiszak** ADDRESS **12 N. Potomac St.**

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic Heart Disease.** (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles E. Fabiszak** CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Charles E. Fabiszak** DATE SIGNED **5/9/65**

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **5/12/65** 23C. NAME of CEMETERY or CREMATORY **Holy Rosary** 23D. LOCATION **Baltimore, Maryland**

24A. DATE REC'D BY HEALTH DEPT. **MAY 11 1965** 24B. NAME OF REGISTRAR **Robert E. Fabiszak** 24C. FUNERAL DIRECTOR **M.F. SADOWSKI & SONS** ADDRESS **1808 EASTERN AVE**

VS 151-REV. 1/1/65

WALLACE PRODIGE

Handwritten notes

Handwritten signature or initials

41-89-86

FR

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4979

BIRTH NO.

65 4979

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

William Davenport

2. DATE AND HOUR OF DEATH

May 7, 1965

9:20

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS

(If rural, give location)

6208 Plantview Way

21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

8-22-1900

9. AGE (In years

last birthday)

64

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work

done during most of working life, even if retired)

Coal miner

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Mack h. Davenport

14. MOTHER'S MAIDEN NAME

Laura Bowden

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

232140337

17. INFORMANT

ADDRESS

RECORDS: BCH 4940 Eastern Avenue 21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION lost.(A) Pneumonia  
DUE TO

2 Weeks

(B) Chronic Obstructive Emphysema  
DUE TO

20 Years

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 27, 1965 to May 7, 1965,  
that (I) (we) last saw the deceased alive on May 7, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

May 7, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Md. 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-II-65

24C. NAME OF CEMETERY or CREMATORY

Cedar Hill Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

25B. NAME OF REGISTRAR

Robert E. Fairley

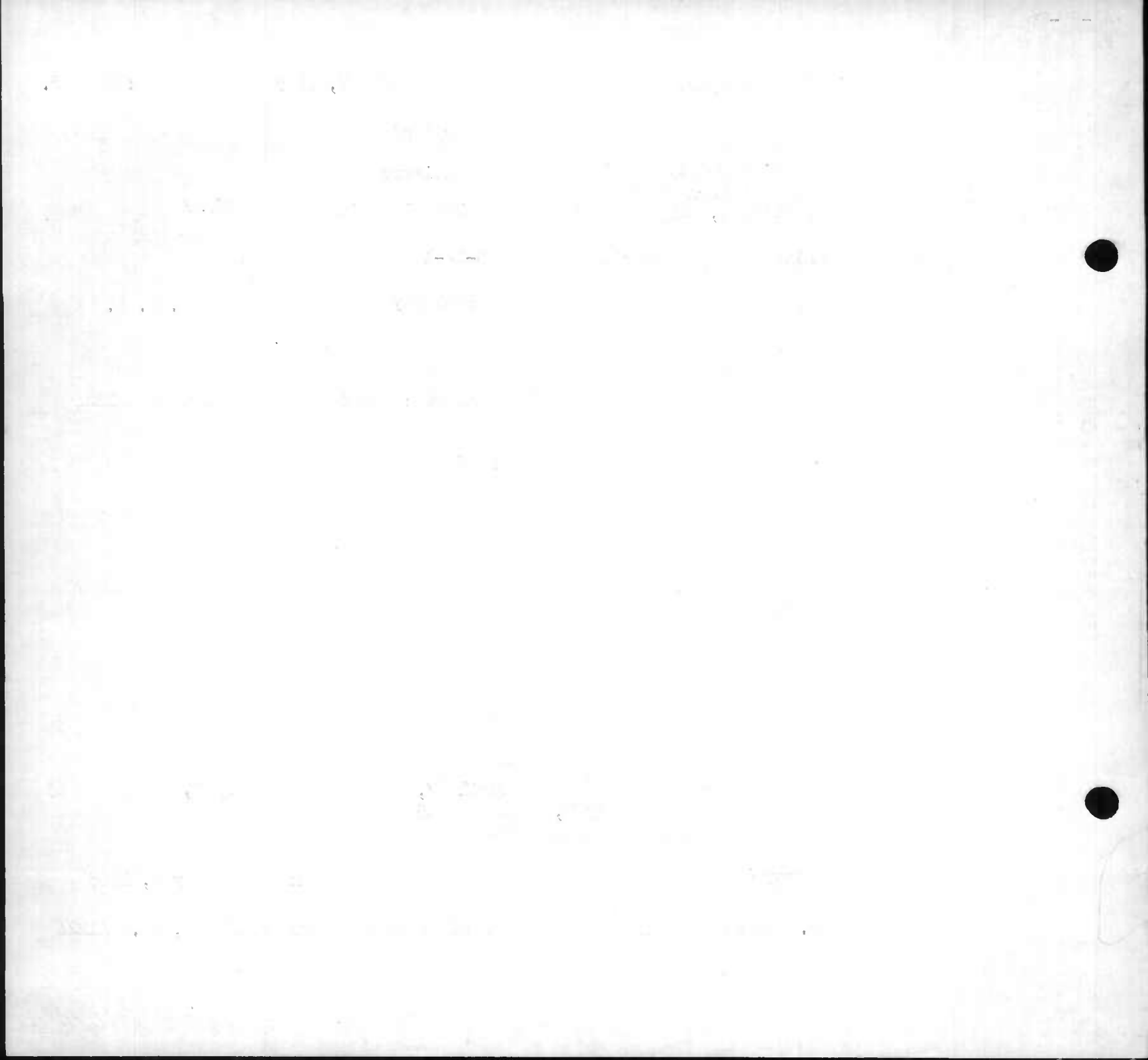
25C. FUNERAL DIRECTOR

Walter Dobrowski 1005 Dundalk Ave

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

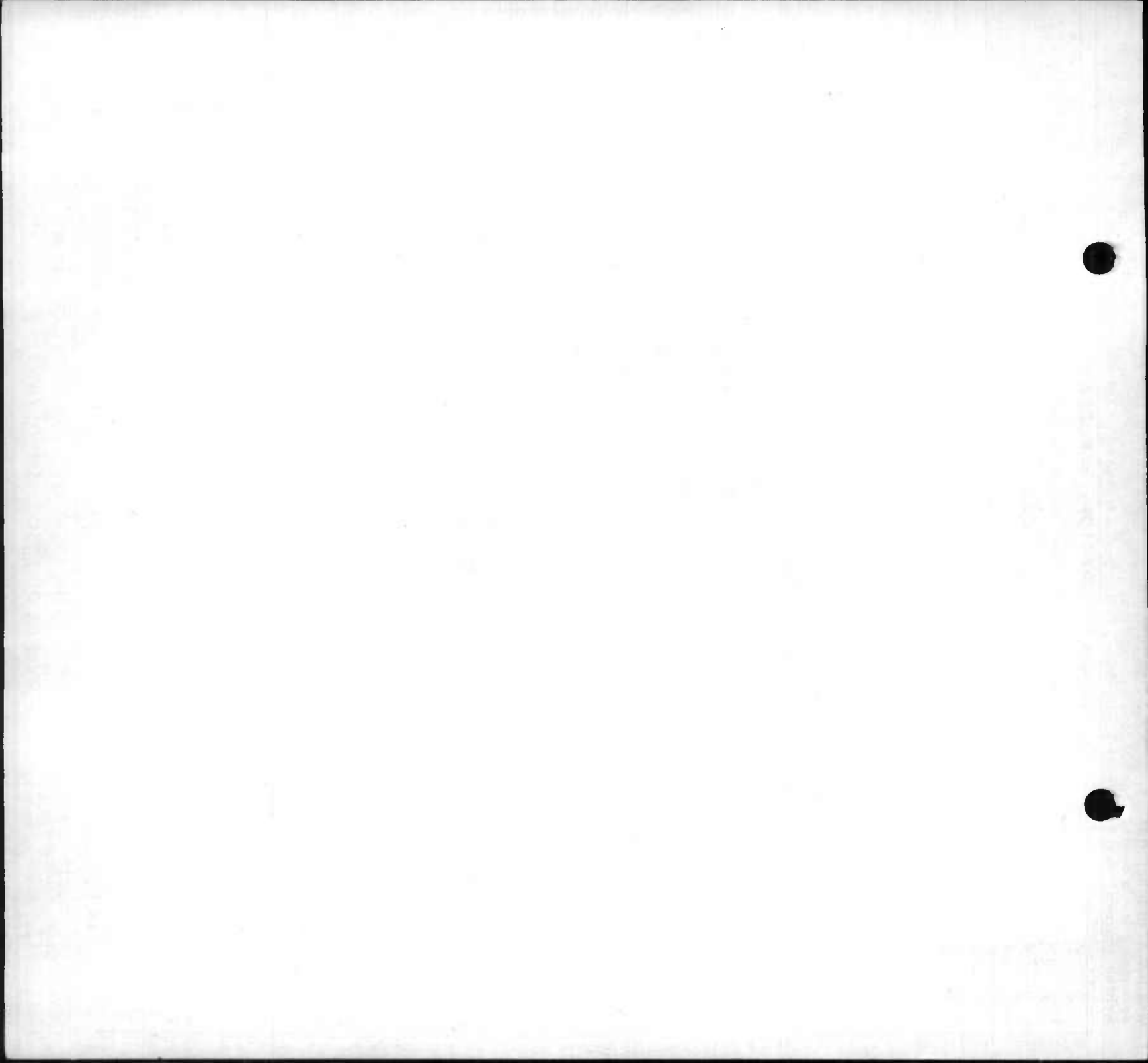
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 4980</b>	
BIRTH NO. <b>65 4980</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ALDER, BENJAMIN H. Sr.</b>		2. DATE AND HOUR OF DEATH <b>5/8/65</b> <b>10<sup>25</sup> P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>24-24</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1723 JACKSON STREET</b>			
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-17-1886</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD EMPLOYEE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>? BENJAMIN F. ALDER</b>		14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FAMILY</b>	
				ADDRESS <b>Same</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Anteromedullary Cardiovascular Disease with Myocardial Infarction</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>MAY 6<sup>th</sup> 1965</b> to <b>MAY 8<sup>th</sup> 1965</b> , that (H) (we) last saw the deceased alive on <b>MAY 6<sup>th</sup> 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Colin C. Heinrich</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>5/8/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>COLIN C. HEINRICH</b>		23D. ADDRESS M.D. <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5-12-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar N.Y. Cem</b>	
		24D. LOCATION <b>Ba Lto. 25 MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>MACON, Frank Ave 130E first ave</b>	
				ADDRESS	

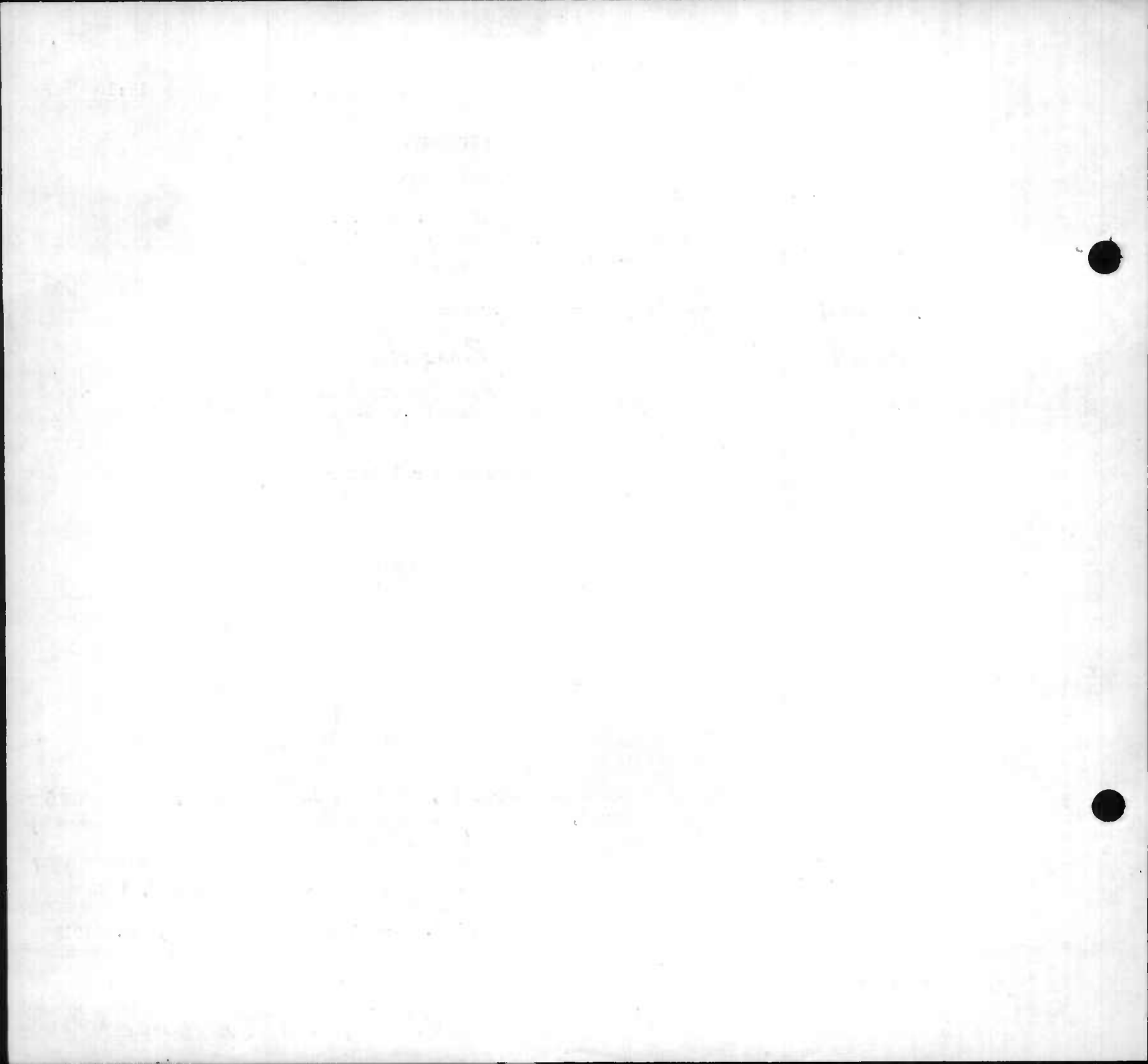




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 4981</u>	
65 4981				CERTIFICATE OF DEATH	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Adams, George (Georgios Adamopoulos)		May 6, 1965 12:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  St. Joseph Hospital		A. STATE Maryland B. COUNTY 8-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 D. STREET ADDRESS (If rural, give location) 1603 N. Gay St.			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1889	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? Greece		13. FATHER'S NAME Michael		14. MOTHER'S MAIDEN NAME Panagiota	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 378-05-4411		17. INFORMANT Mrs. Constantine Adams 1603 N. Gay Street, Baltimore Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 332X I DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Right cerebral infarct DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 19, 1965 to May 6, 1965, that (I) (we) last saw the deceased alive on May 6, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William B. VandeGrift, M.D.				23B. DATE SIGNED May 6, 1965	
23C. PHYSICIAN'S NAME (Type) William B. VandeGrift, M.D.				23D. ADDRESS 1400 N. Caroline St., Baltimore, Md. 21213	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-65		24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. MAY 11 1965			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Nicholas T. Matthews 13021 Eastern Ave., Baltimore, Md. 21224			



534498  
TANNEY, MARIE VIR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

**CERTIFICATE CORRECTED 6-7-65**

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

THE JOHNS HOPKINS HOSPITAL

BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No.

65 4982

2. DATE AND HOUR OF DEATH

8 May 1965 7:30 P.M.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

100 W. COLDSRING LANE

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

9-24-02

9. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Secretary (retired)

10B. KIND OF BUSINESS OR INDUSTRY

Stieff Silver Co.  
The Stieff Company

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LOUIS TANNEY

14. MOTHER'S MAIDEN NAME

ELIZABETH QUITEL

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine Collier, Spencerville, Md

18.

421315-260X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

Circulatory Collapse & Hypotension 3 hours

Pulmonary insufficiency at least 2 years

Congestive Heart Failure & Edema > 1 year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Maturity onset diabetes

?

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐

Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from April 9 1965 to May 8 1965,  
that (I) lost saw the deceased alive on May 8 1965 and that in (my) opinion death occurred on the date  
and hour and from the causes stated above. (I) (did) view the body after death.

23A. SIGNATURE

L.J. Buckels M.D.

M.D.

Attending  
Phys. ☐

Med.  
Director ☐

Staff  
Phys. ☒

23B. DATE SIGNED

8 May 1965

23C. PHYSICIAN'S  
NAME (Type)

L.J. Buckels M.D.

M.O.

23D. ADDRESS

The Johns Hopkins Hospital - Baltimore

24A. BURIAL CREMATION,  
REMOVAL (Specify)

CREMATION

24B. DATE

5-10-65

24C. NAME of CEMETERY or CREMATORY

Green Mount

24D. LOCATION

Baltimore

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc., 1217 St. Paul Street

Letter from The Stieff Company 6-7-65 M.H.

41-05-92 IB 1

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4983

BIRTH NO.

65 4983

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

M.

Kathleen Cross

2. DATE AND HOUR OF DEATH

5-6-65

6 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 21205

D. STREET ADDRESS (If rural, give location)

2021 Mc Elderry St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9-26-02

9. AGE (In years  
last birthday)

62

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick County, Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles E. Booth

14. MOTHER'S MAIDEN NAME

Grace W. Thompson

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-30-3356

17. INFORMANT

ADDRESS

RECORDS-BCH-4940 Eastern Avenue #21224

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cardiac Arrest  
DUE TO

Minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) Myocardial Infarct  
DUE TO

Days

(C) Diabetes Hypertension

Years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-3 19 64 to 5-6 19 65,  
that (I) (we) last saw the deceased alive on 5-6 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys. ☐Med.  
Director ☒Staff  
Phys. ☐

23B. DATE SIGNED

5-6-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Howard Rathbun

23D. ADDRESS

M.D. 4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

5-11-65

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION

(City, town, or county)

Woodlawn, Md

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

25B. NAME OF REGISTRAR

Robert E. Farley

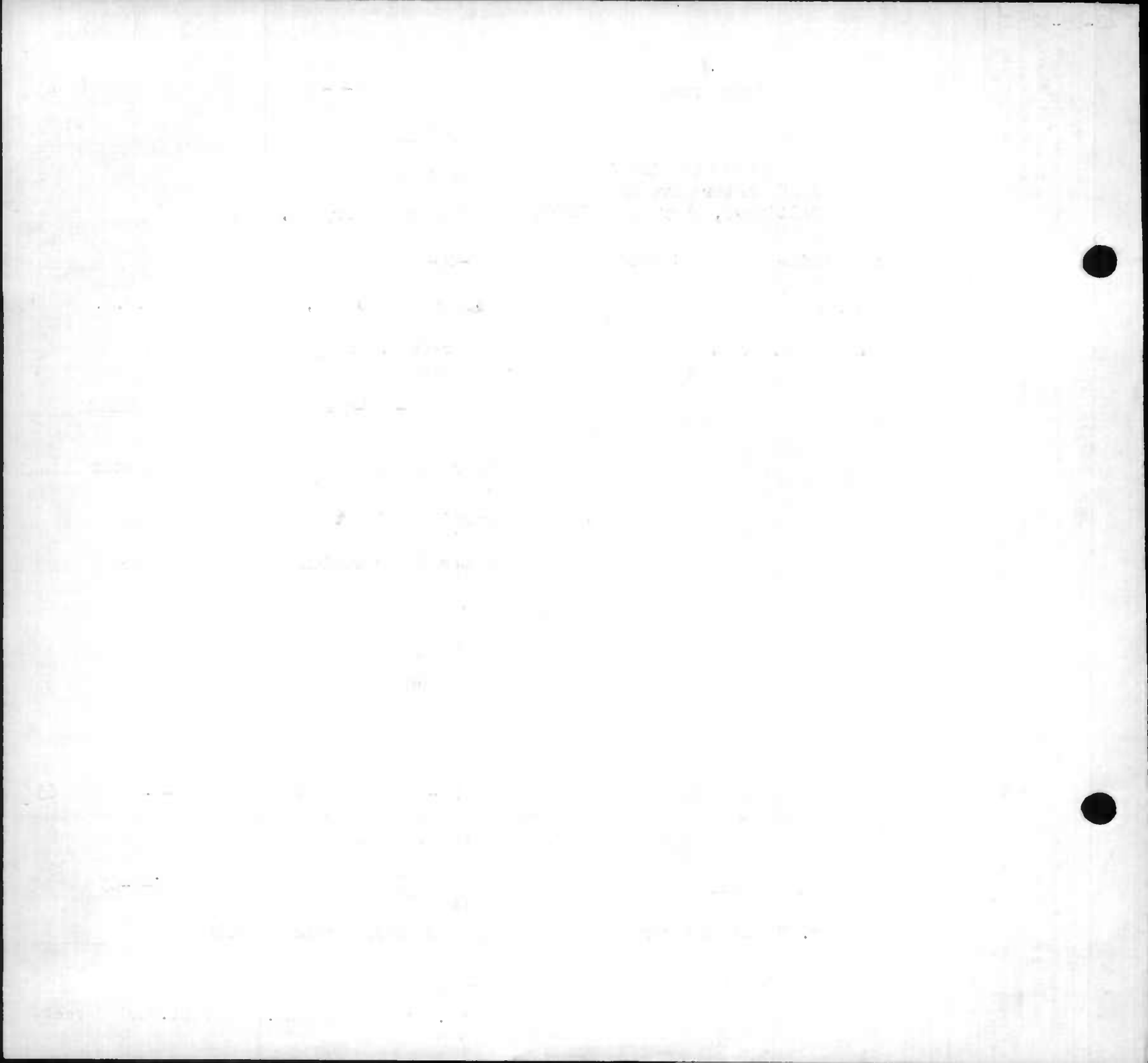
25C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc., 1217 St. Paul Street

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4984				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4984	
1. NAME OF DECEASED (Type or Print) <i>Stephen R. Lievers</i>				2. DATE AND HOUR OF DEATH <i>May 9, 1965 11:45 A.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>18-02</i>			
5. SEX <i>M</i> 6. RACE <i>N</i> 7. (MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify))				8. DATE OF BIRTH <i>12/15/1891</i>		9. AGE (In years lost birthday) <i>73</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Frank Lievers</i>				14. MOTHER'S MAIDEN NAME <i>Margaret E. Alston</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sarah Jackson</i> ADDRESS <i>same</i>	
18. <i>610X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Enlarged prostate</i> DUE TO (B) <i>Uremia</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 4, 1965</i> to <i>May 7, 1965</i> , that (I) (we) last saw the deceased alive on <i>May 15, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kyo Rak Lee</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>May 9, 1965</i>	
23C. PHYSICIAN'S NAME (Type) <i>Kyo Rak Lee</i>				23D. ADDRESS <i>Franklin Square Hosp</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-12-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore, National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore City</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltner</i>		25C. FUNERAL DIRECTOR <i>Isaiah L. Brown and Son</i>		ADDRESS <i>1108 W. Montgomery Street</i>	

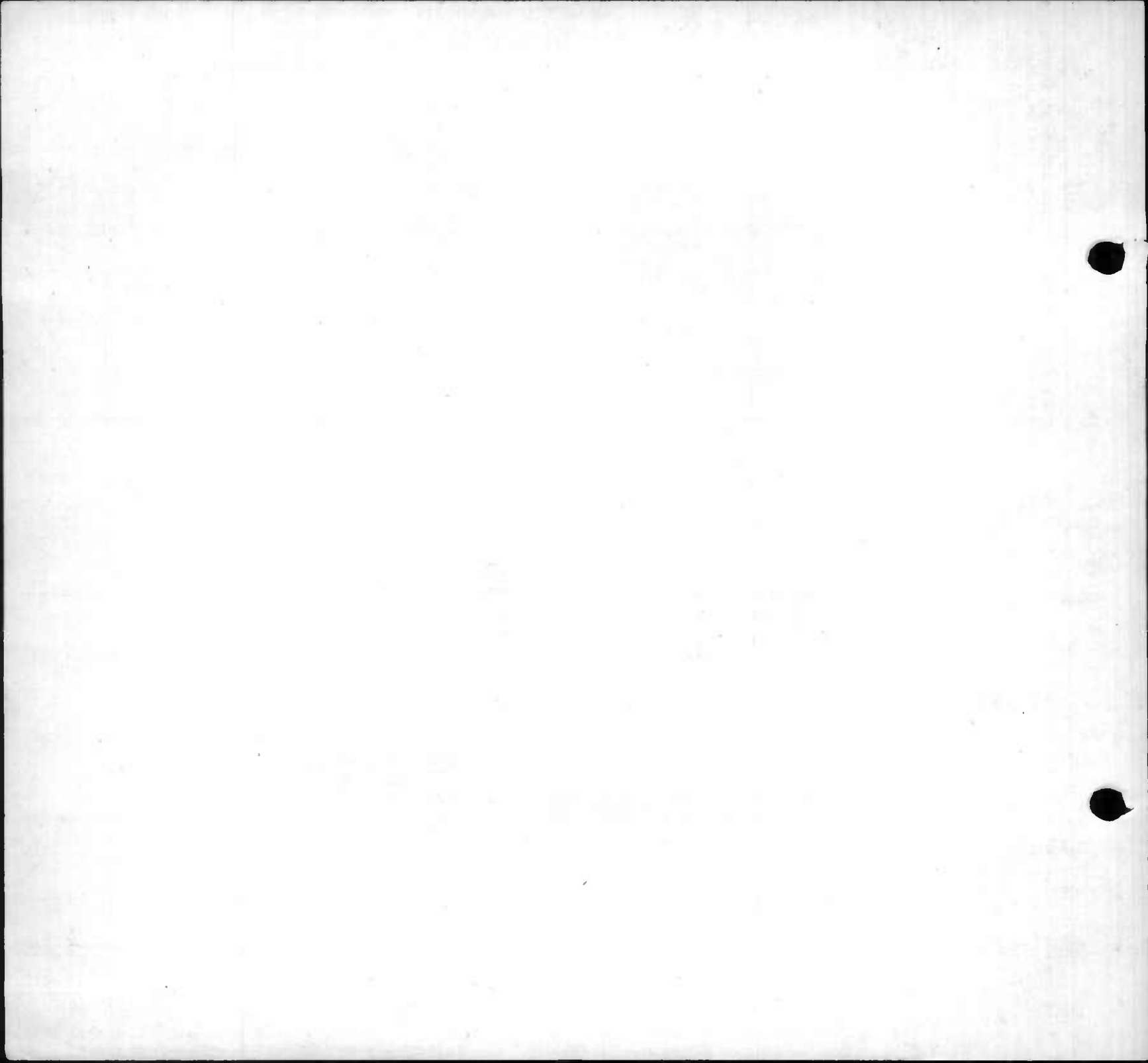




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

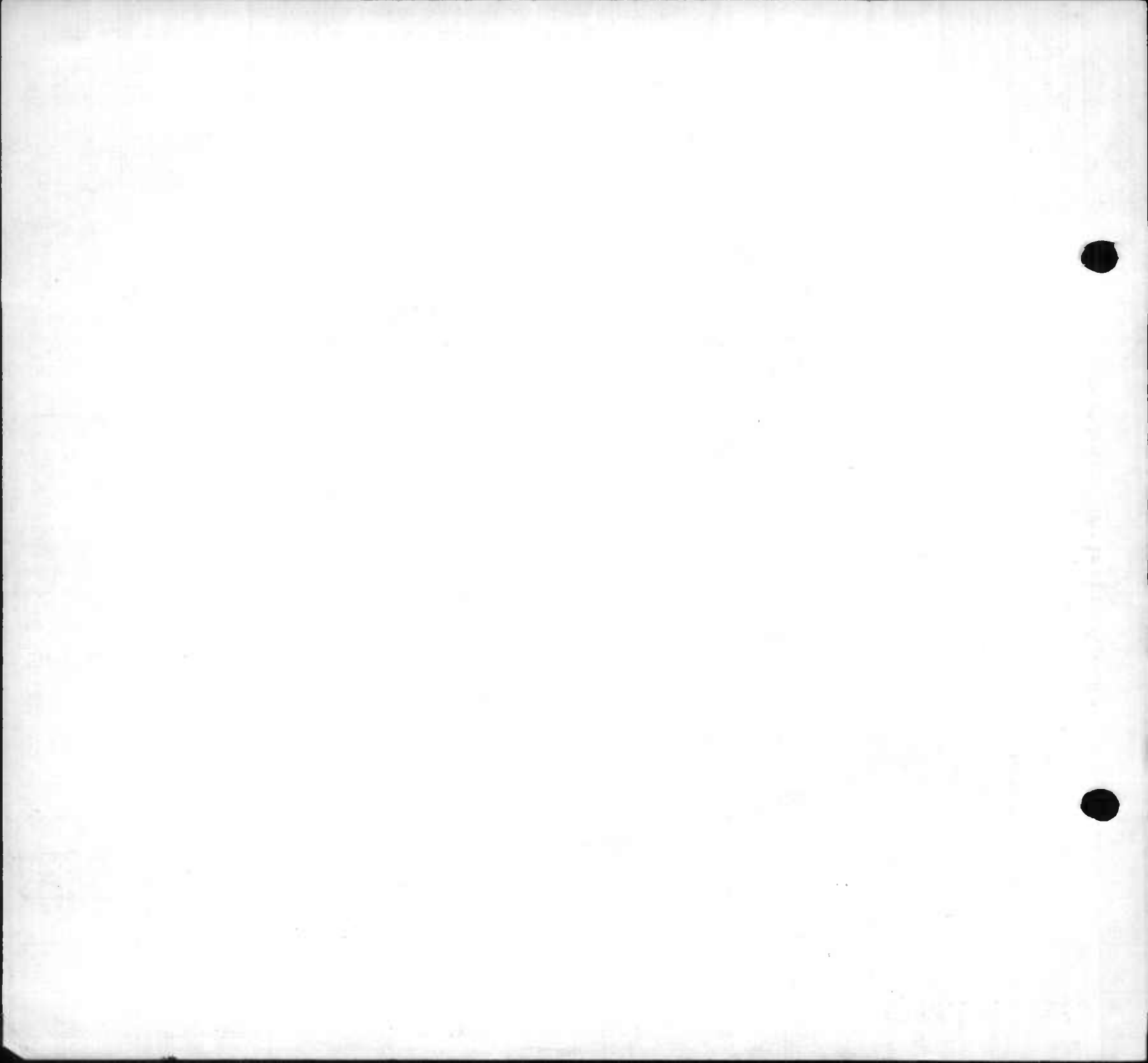
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <u>65 4985</u>	
BIRTH NO. <u>65 4985</u>							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>GEORGE HERBERT CAMPBELL</u>				2. DATE AND HOUR OF DEATH <u>5/10/65 12:50 P.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>23-01</u>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
				D. STREET ADDRESS (If rural, give location) <u>1002 PEACH ST.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SEP</u>		8. DATE OF BIRTH <u>1/28/07</u>	9. AGE (in years last birthday) <u>59</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HELPER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ROBERT C. CAMPBELL</u>				14. MOTHER'S MAIDEN NAME <u>EMMA DORSEY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>PATIENT</u>		ADDRESS	
18. <u>163X-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF LUNG</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>CARCINOMA OF LUNG</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> 19 <u>65</u> to <u>5/7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>5/7</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles H. Asplen</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5/11/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Charles H. Asplen</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5/11/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Int. Auburn &amp; Calb City</u>		24D. LOCATION (City, town, or county) (State) <u>Balt City</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor</u>		ADDRESS <u>108 W. Montross St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 4986</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4986</span>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">RODNEY WELLS</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">MAY 7 1965 2 30 A M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">38 UNIVERSITY HOSPITAL</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">BALTIMORE 20-01</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">4008 W. FRANKLIN</span>			
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">SINGLE</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10/17/56</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">8</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">STUDENT</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">WILLIAM P. WELLS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">VIRGINIA HULLAND</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <span style="font-size: 1.2em;">200.01</span>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) <span style="font-size: 1.2em;">RETICULUM CELL</span> DUE TO <span style="font-size: 1.2em;">SARCOMA</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">7 MONTHS</span>	
(B) DUE TO		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">October 12 1965</span> to <span style="font-size: 1.2em;">MAY 7 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">MAY 7 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Kenneth Mott</span>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">May 7 1965</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">KENNETH MOTT</span>		23D. ADDRESS M.D. <span style="font-size: 1.2em;">University Hospital Baltimore</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">5/12/1965</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Balto National Cal</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto Md</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">MAY 11 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fairbank</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">C. Roy C. Wilson 1000 Brantly Ave</span>	



BIRTH NO.

65 4987

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4987

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY CORNELIUS

2. DATE AND HOUR PRONOUNCED DEAD

5-9-65

5:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. JOSEPH'S HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2049 Llewellyn Avenue 21207

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

March 3, 1901

9. AGE (In years  
last birthday)

64

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

Pittsylvania Co. VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert J. Hubbard

14. MOTHER'S MAIDEN NAME

Emma Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒DATE SIGNED  
5-10-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-13-65

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

24B. NAME OF REGISTRAR

Robert E. Finkbeiner

24C. FUNERAL DIRECTOR

E. G. Wilson 1000 Brantley Ave.

ADDRESS

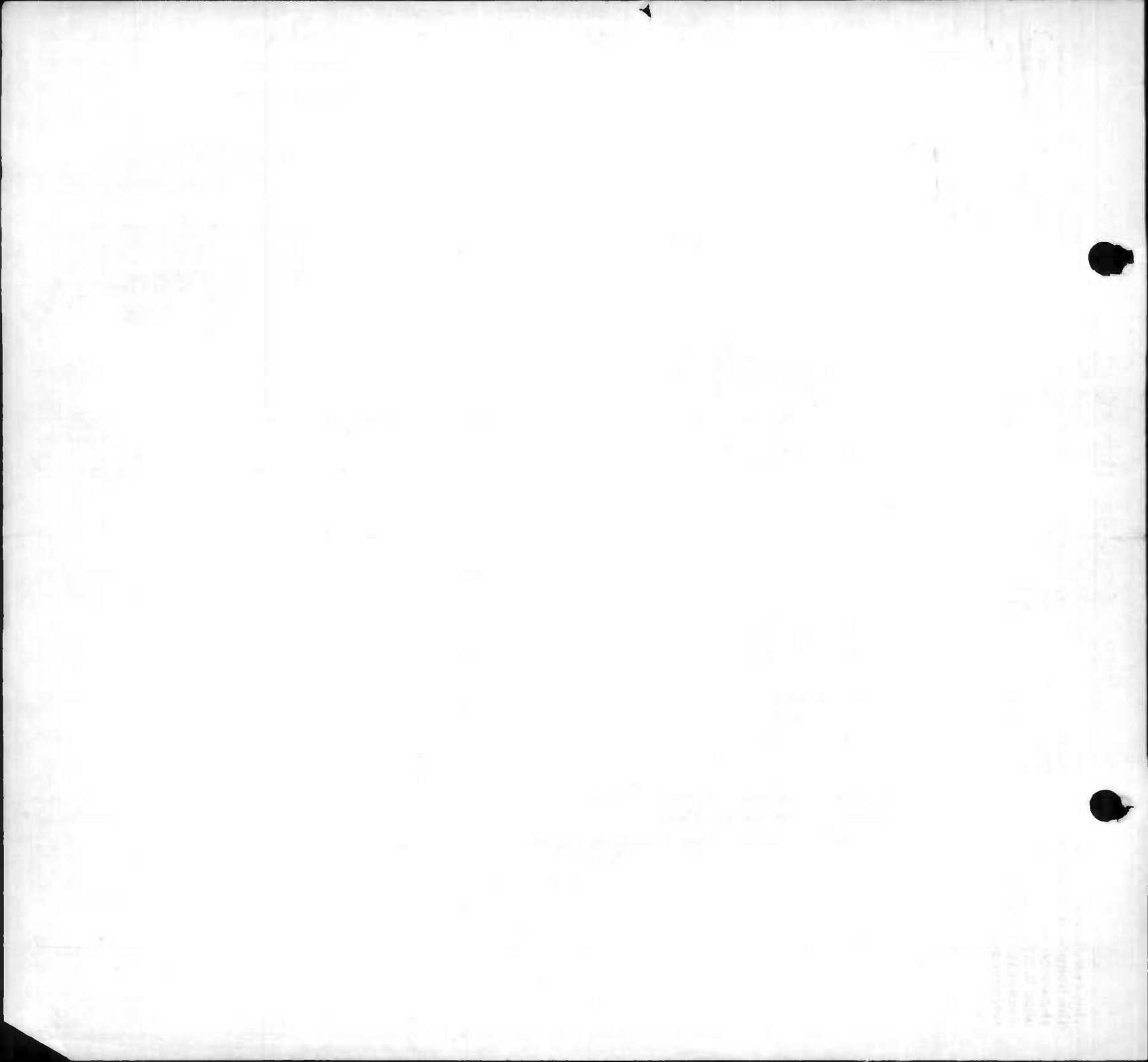
WALTER H. BROWN

PAID CONTENT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 4988					CERTIFICATE OF DEATH					Registered No. 65 4988				
1. NAME OF DECEASED (Type or Print) <u>Florence B. Gerke</u>					2. DATE AND HOUR OF DEATH <u>May 7 1965 5:45AM</u>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>18 The Gundry Sanitarium Inc</u>					A. STATE <u>Maryland</u>					B. COUNTY <u>28-04</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 2 N. Wickham Rd.</u>									
					D. STREET ADDRESS (If rural, give location) <u>unknown</u>									
5. SEX <u>F</u>		6. RACE <u>white</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>		8. DATE OF BIRTH <u>6-10-1974</u>		9. AGE (In years last birthday) <u>90</u>		If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>					11. BIRTHPLACE (State or foreign country) <u>MD</u>				
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					13. FATHER'S NAME <u>Charles Gerke</u>					14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>-</u>					17. INFORMANT <u>Charles J. Peach</u>				
					ADDRESS <u>512 Cathedral ST, Baltimore 1, Md</u>									
18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial failure</u>										<u>24 hrs</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic myocardial failure = Fibrillation</u>										<u>6 yrs</u>				
<u>Arteriosclerosis - general/cerebral</u>										<u>10 yrs</u>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Paranoid Schizophrenia</u>										<u>20 yrs or more</u>				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>3 - 2</u> 19 <u>55</u> to <u>May 7</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>5 - 6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <u>Rachel K. Gundry</u>										M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>				
23B. DATE SIGNED <u>May 7, 1965</u>														
23C. PHYSICIAN'S NAME (Type) <u>Rachel K. Gundry</u>					23D. ADDRESS <u>The Gundry Sanitarium Inc 2 N. Wickham Rd. Baltimore 29 Md</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>5/10/65</u>					24C. NAME OF CEMETERY OR CREMATORY <u>Lawson Park</u>				
					24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 11 1965</u>					25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>					25C. FUNERAL DIRECTOR <u>Leopold Beyer</u>				
					ADDRESS <u>8728 Liberty Rd. Randallstown</u>									

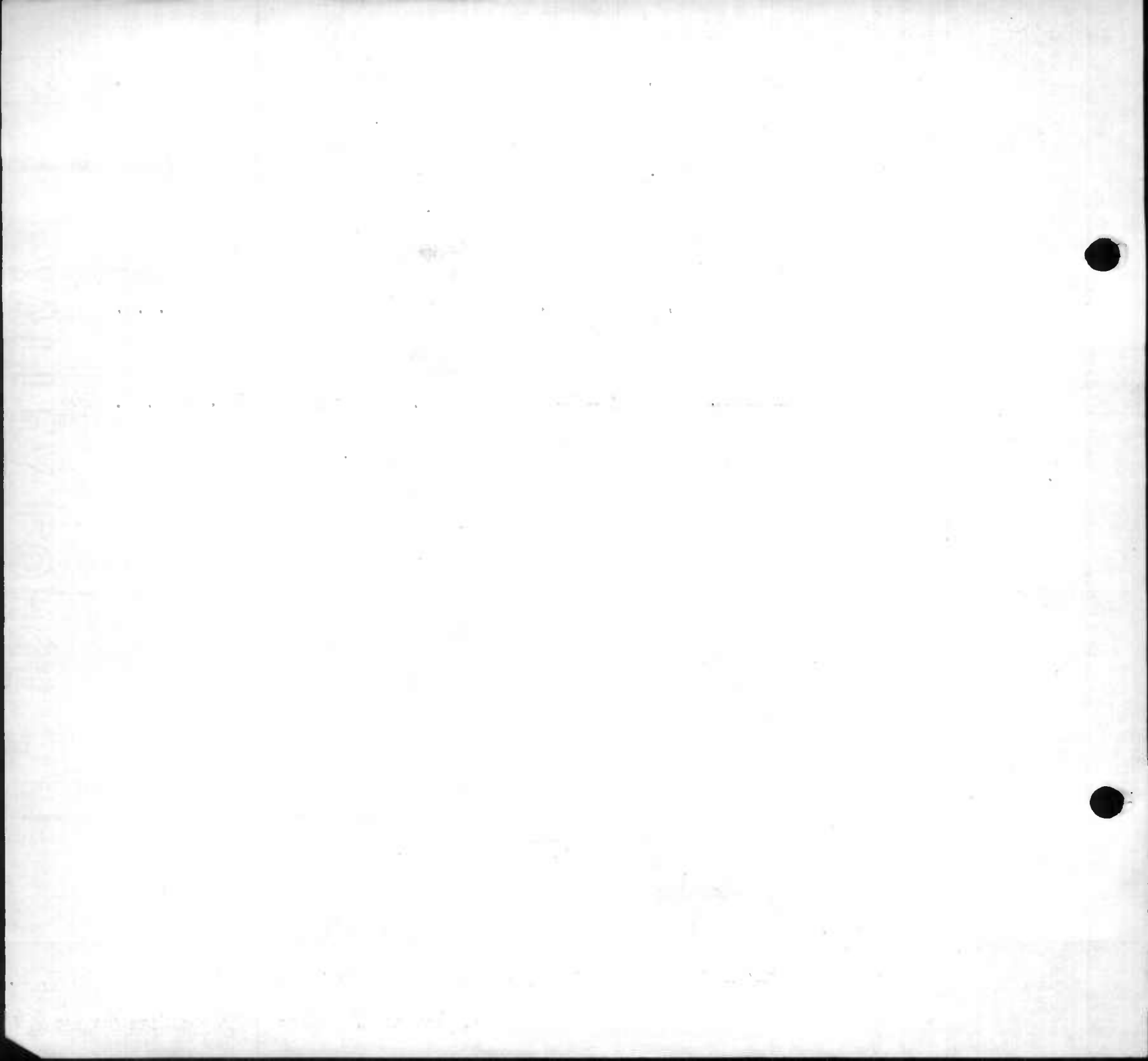




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

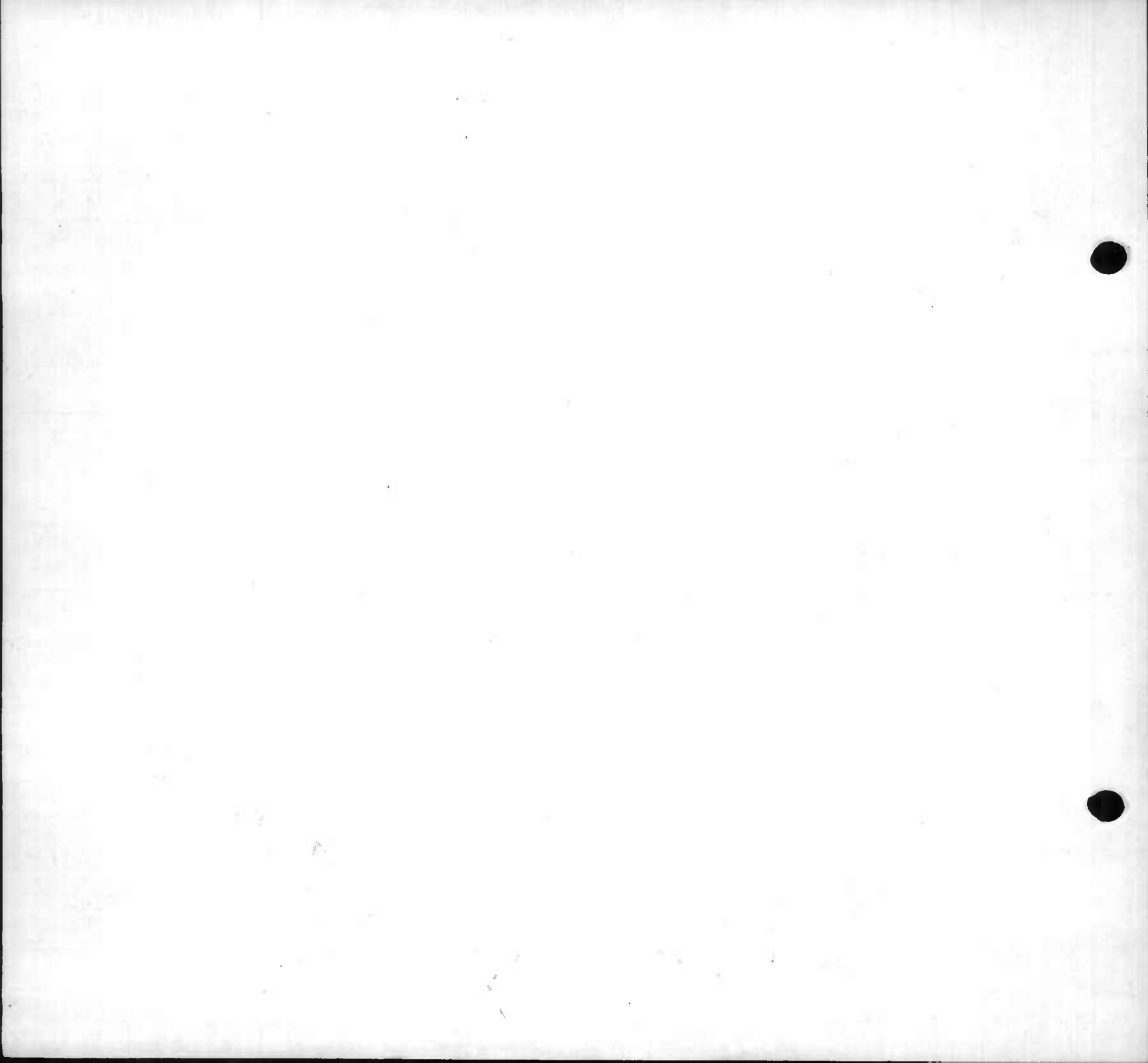
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 4989				
BIRTH NO. 65 4989									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) ELI POPE Sr.					2. DATE AND HOUR OF DEATH 5-9-65 12.50 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL					A. STATE MARYLAND				
					B. COUNTY BALTIMORE				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 6914 FAIT AVE #24				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED MARRIED	8. DATE OF BIRTH 6-26-85	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Rumania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAM POPE			14. MOTHER'S MAIDEN NAME Anna ?						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-03-2252		17. INFORMANT ADDRESS Mary R. Gallagher 606 S. 48th St. #24				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 154X I CAUSE OF DEATH Metabolic & Respiratory Alkalosis INTERVAL BETWEEN ONSET AND DEATH 24 hours									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) Small Bowel obstruction 10 days (B) Paralytic Ileus & Organic obstruction 10 days									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Adenocarcinoma of Rectosigmoid Colon approx 3 years									
19A. DATE OF OPERATION 4-26-65 5-5-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Rectum & Small bowel obstruction		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 4-19-65 19 to 5-9-65 19, that (we) last saw the deceased alive on 5-9-65 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE R. Darryl Fisher, MD					23B. DATE SIGNED 5-9-65				
23C. PHYSICIAN'S NAME (Type) R. DARRYL FISHER					23D. ADDRESS JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-65		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery		24D. LOCATION (City, town, or county) (State) 7401 German Hill Road Balto. 22, Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler 6224 Eastern Avenue #24					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 4990	
BIRTH NO. 65 4990		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MAUDE CLARK		2. DATE AND HOUR OF DEATH 5-7-65 5:30 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD		B. COUNTY 19-01	
36 FRANKLIN SQ. HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		1613 SARAH ANN ST #23	
5. SEX I	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO RIGHT UPPER LOBE PNEUMONIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CA(?) ovary			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 5-3-65 19 to 5-7-65 19, that (I) (we) last saw the deceased alive on 5:30 AM. 5-7-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROYCE A. FERRER		23D. ADDRESS ANATOMY BOARD OF MARYLAND, JOHNS HOPKINS MEDICAL SCHOOL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE OF BURIAL CREMATION, REMOVAL MAY 17 1965		24C. NAME OF CEMETERY OR CREMATORIAL HOME AND LOCATION BALTIMORE, MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BEND Ethel H. Conell - a new funeral home	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		65 4991	
BIRTH NO. 65-1127365 4991		Registered No. 65 4991	
M.E. CASE NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Stuller Baby Girl		2. DATE AND HOUR OF DEATH 5/6/65 11.32 p M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Harford C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air 21014 D. STREET ADDRESS (If rural, give location) 217 St Thomas St	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 5/6/65
9. AGE (In years last birthday)		10. UNDER 1 Yr. Months: Days: Hours: Min.	11. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore
13. FATHER'S NAME William J. Stuller		14. MOTHER'S MAIDEN NAME Loretta M. Sowden	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Premature Baby ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DUE TO (B) (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 5/6/65 to 5/6/65, that (I) (we) last saw the deceased alive on 5/6/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Antoinette Arrage M.D.		23B. DATE SIGNED 5/7/65	
23C. PHYSICIAN'S NAME (Type) Antoinette Arrage		23D. ADDRESS Church Home & Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE MAY 11 1965	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

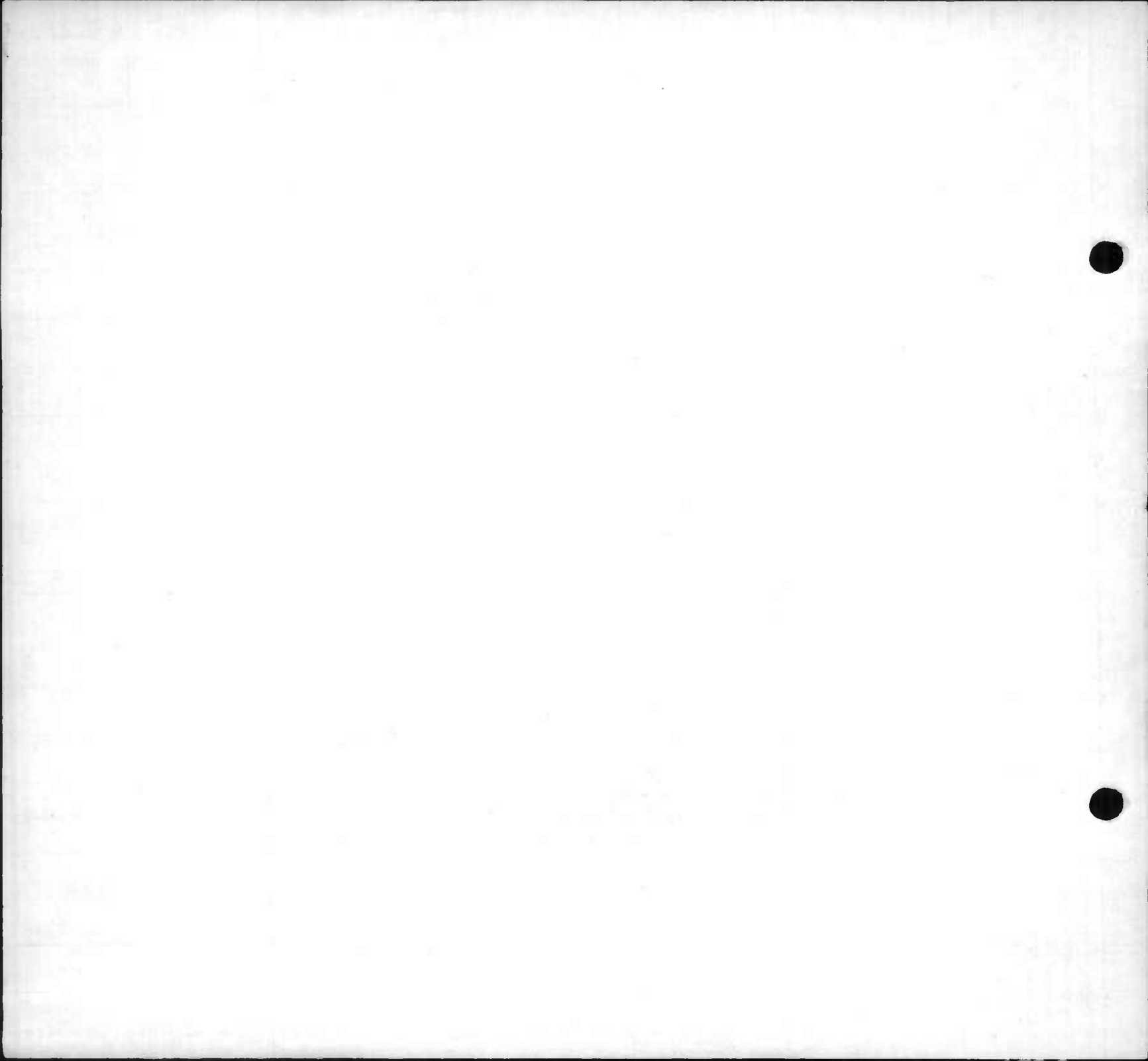
John A. Brown

X

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
BIRTH NO. 65-11031		65 4992		CERTIFICATE OF DEATH				Registered No. 65 4992			
1. NAME OF DECEASED (Type or Print) <b>BABY BOY WEBB</b>						2. DATE AND HOUR OF DEATH <b>5-8-65 6:00 A. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GEN'L HOSPITAL</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>OWINGS MILLS 5300</b> D. STREET ADDRESS (If rural, give location)					
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>N.B.</b>		8. DATE OF BIRTH <b>5/8/65</b>		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ARTHUR ANDREW WEBB</b>						14. MOTHER'S MAIDEN NAME <b>PATRICIA YAEGER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
18. CAUSE OF DEATH											
<div> <div> <b>I</b>  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>Immunization</b>  (A) DUE TO </div> <div> <b>II</b>  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  (B) DUE TO </div> <div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  (C) DUE TO </div> </div>											
<div> <div> <b>19A. DATE OF OPERATION</b>  <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> </div> <div> <b>20A. AUTOPSY? (Yes or No)</b>  <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> </div> </div>											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>5-8-1965</b> to <b>5-8-1965</b> that (I) (we) last saw the deceased alive on <b>6 PM 5-8-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>[Signature]</b> M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>5-8-65</b>	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <b>MAY 11 1965</b>		24C. NAME of CEMETERY or CREMATORY <b>ANATOLY BOARD OF MARYLAND</b>				24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>MAY 11 1965</b>				25B. NAME OF REGISTRAR <b>John E. Faldut</b>				25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>			

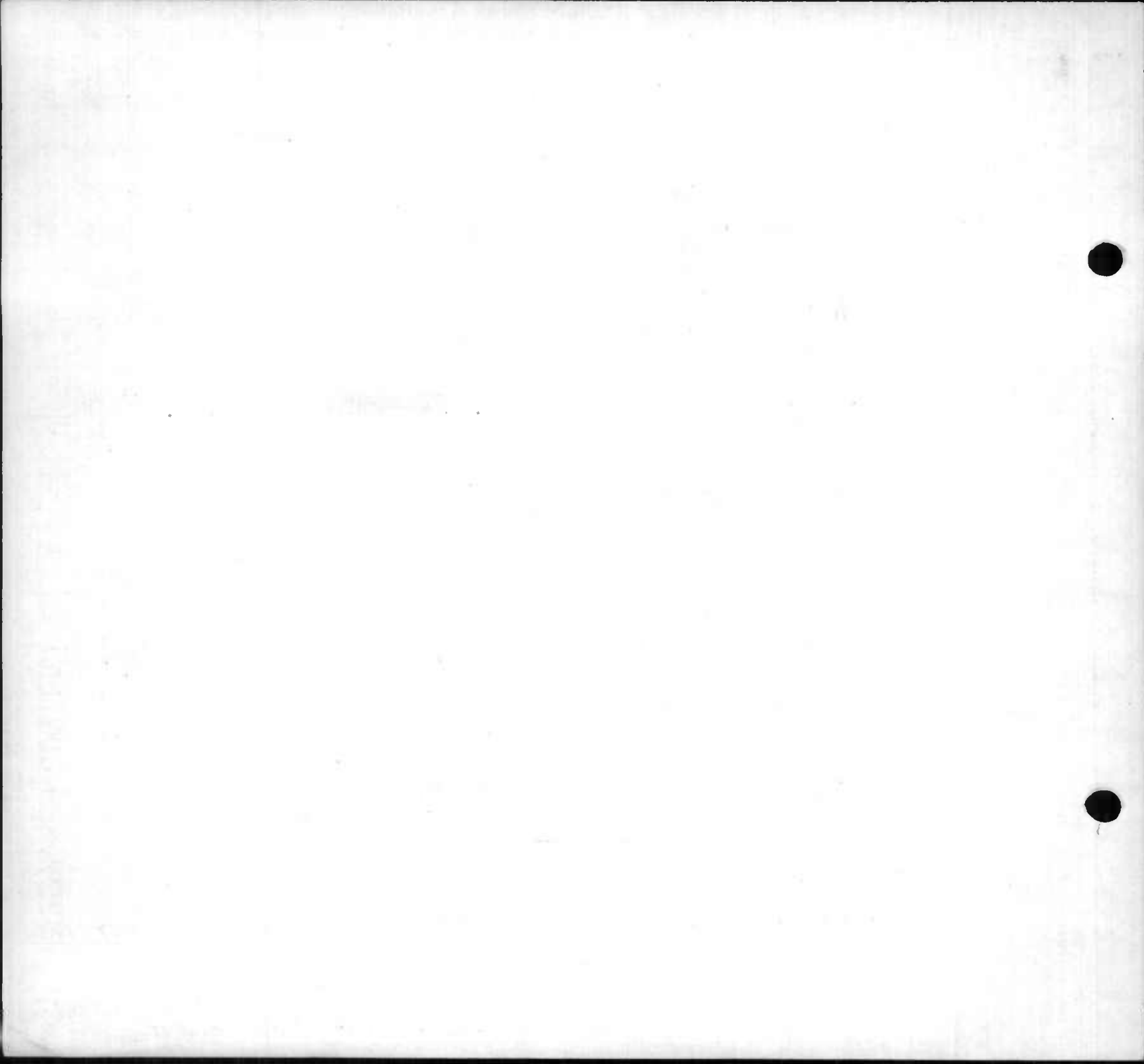




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4993		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4993	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) HELEN W. MITTEN		
2. DATE AND HOUR OF DEATH 5/10/65 8:30 P.M.			3. PLACE OF DEATH IN BALTIMORE, MARYLAND		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore		
C. CITY OR TOWN (If outside city limits, write RURAL and give township) TOWSON			D. STREET ADDRESS (If rural, give location) 623 SUSSEX ROAD		
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 2-6-90	9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF
10B. KIND OF BUSINESS OR INDUSTRY NONE			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES STEPHEN WHITBY			14. MOTHER'S MAIDEN NAME MARY LOUISE JONES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. C. Emory Mitten
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) Congestive Heart Failure		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 5/10/65 to 5/10/65, that (he) (we) last saw the deceased alive on 5/10/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William N. Bennett			23B. DATE SIGNED 5/10/65		
23C. PHYSICIAN'S NAME (Type) William N. BENNETT			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/13/1965		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Maryland		24E. LOCATION (City, town, or county) Baltimore, Maryland		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Faldut		25C. FUNERAL DIRECTOR W.B. Dickinson	
25D. ADDRESS Balto., Md. 21217		25E. ADDRESS North Park Ave.			



1  
g 650

65 4994

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4994

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EARL GRAHAM

2. DATE AND HOUR PRONOUNCED DEAD

May 8, 1965 9:45 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1143 N. Mount Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1143 N. Mount Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

3/17/1932

9. AGE (In years last birthday)

33 30

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

CONTRACTOR

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

FRANK GRAHAM

14. MOTHER'S MAIDEN NAME

DEW M. VAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213-28-7960

17. INFORMANT

ADDRESS

DOUG G. ARMSTRONG 1037 N WOLF ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis and Fibrosis.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 5/9/65

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 11 1965

Robert E. Taylor, M.D.

Marshall P. Hays 638 N. Green St

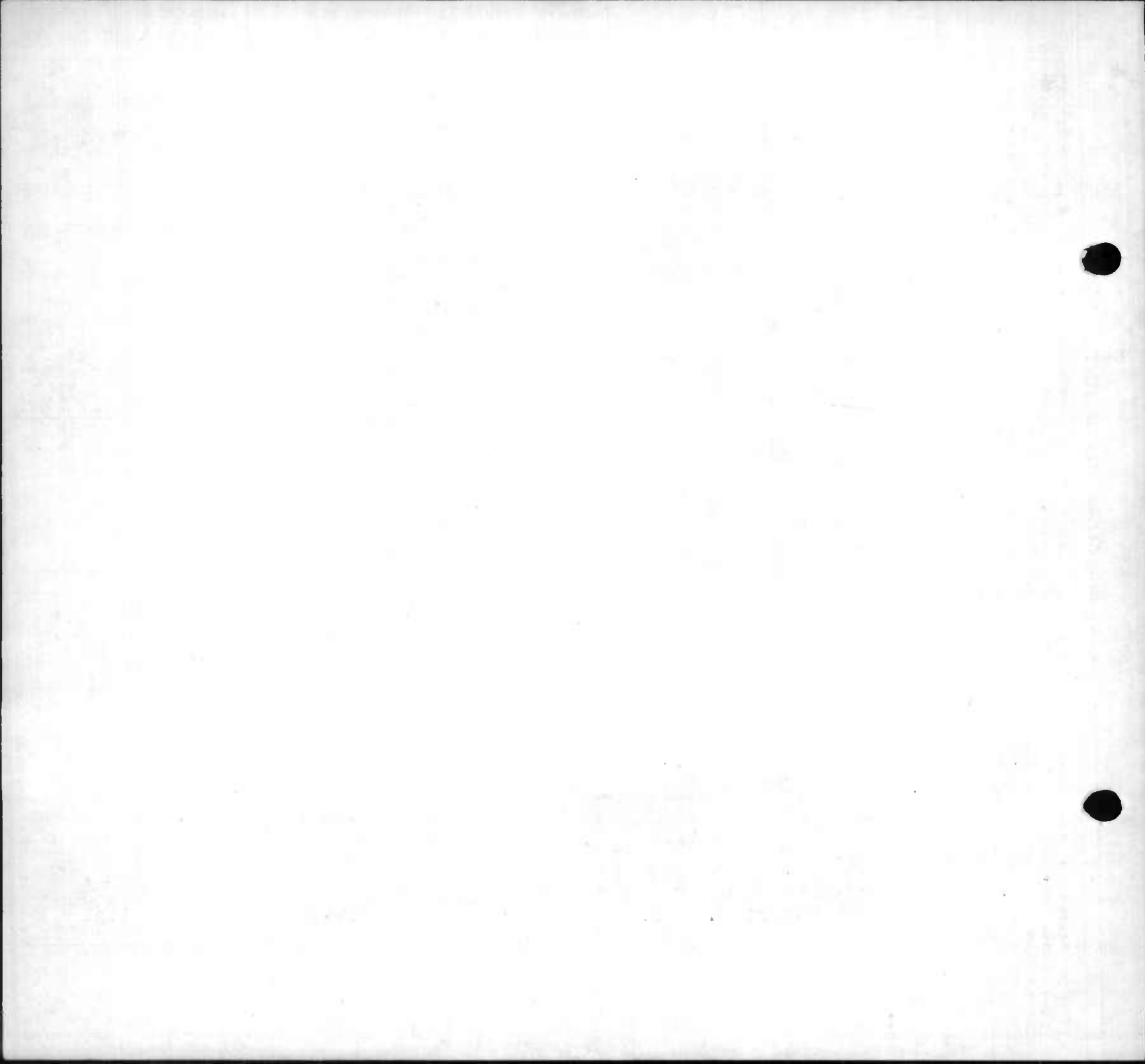
9650005002



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 4995		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 4995	
CERTIFICATE OF DEATH					
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Vera Boston (AKA Vernamae)			
2. DATE AND HOUR OF DEATH		5/7/65 4:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md. B. COUNTY 11-04			
Montebello State Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
D. STREET ADDRESS (If rural, give location)		1205 Druid Hill Ave.			
5. SEX F	6. RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married	8. DATE OF BIRTH 3/23/24	9. AGE (in years last birthday) 41	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charlie Williams		14. MOTHER'S MAIDEN NAME —	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 223-40-4428		17. INFORMANT Clarence Garrison 1205 Druid Hill	
18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) cardiac arrest			
		(B) cerebral decortication			
		(C) cardiac arrest 5 wks.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/22/1965 to 5/7/1965, that (I) (we) last saw the deceased alive on 5/7/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert W. Ireland M.D.		23B. DATE SIGNED 5/7/65			
23C. PHYSICIAN'S NAME (Type) Robert W. Ireland		23D. ADDRESS Montebello State Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/65		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Brooklyn Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Joseph L. Russ 2202 N. North Ave. Baltimore, Md.	



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

65

4996

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 4996

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILHEMINA CHANDLER

2. DATE AND HOUR PRONOUNCED DEAD

5-9-65

7:41 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

13-01

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2477 Callow Avenue 21217

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

JAN. 3 1910

9. AGE (In years  
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

S

14. MOTHER'S MAIDEN NAME

S

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Robert Chandler 2477 Callow Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-10-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5-13-65

23C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 11 1965

Robert E. Taylor, M.D.

George H. Kuhn 1348 N. Callow St.



VALLEY FORCE



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)~~EARL MILTON~~ REESE, MILTON EARL

2. DATE AND HOUR PRONOUNCED DEAD

5-10-65

11:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1529 N. Kenwood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1526 N. Kenwood Avenue 21213

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug. 9, 1936

9. AGE (in years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Reese

14. MOTHER'S MAIDEN NAME

Minnie Certis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Jessie Reese 1003 Darley Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH.  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of chest with hemothorax  
DUE TOANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1526 N. Kenwood Avenue

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) 9:10  
5 10 '65 AM

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot wife in back -  
The shot self with 32 cal. revolver

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

5-10-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

5/13/65

23C. NAME OF CEMETERY or CREMATORY

Church Cem.

23D. LOCATION (City, town, or county)

Greenville, N.C.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAY 11 1965

Robert E. Farber

George A. Miller 1348 N. Calhoun St.

vs 153 signed the funeral director. 6/9/65 C. Borens

42-39-68 AM

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 4998

BIRTH NO.

65 4998

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Bertha Hanesworth (Boyd)

2. DATE AND HOUR OF DEATH

5-10-65

3:45 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1643 North Warwick Avenue #21216

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8-17-97

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Shaderick Watkins

14. MOTHER'S MAIDEN NAME

Julia Flormory

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
231-50-8246

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoarthritis, etc. It means the disease,  
injury or complication which caused death.)(A) Several Strokes  
DUE TO

3 Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B) Arteriosclerotic Cardio Vascular  
DUE TO Disease

?

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Not While  
Work At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-17 19 64 to 5-10 19 65  
that (I) (we) last saw the deceased alive on 5-10 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Philip Zieve

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

X

23B. DATE SIGNED

5-10-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Philip Zieve

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

5-13-65

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park

24D. LOCATION

Arbutus

(City, town, or county)

Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 11 1965

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Morton &amp; Dyett

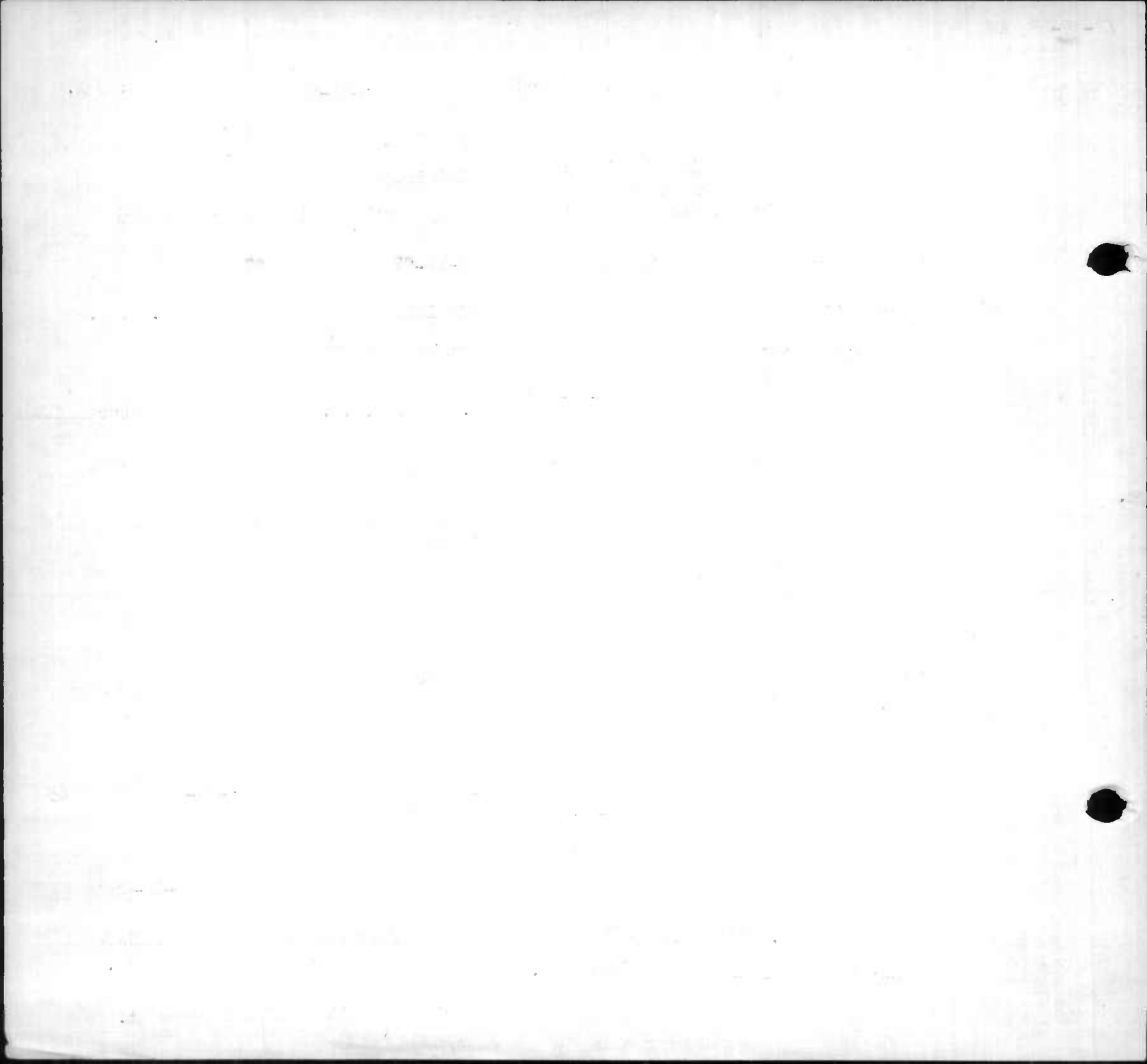
ADDRESS

1701 Laurens St.

19650005000

FUNERAL DIRECTOR: IMPORTANT

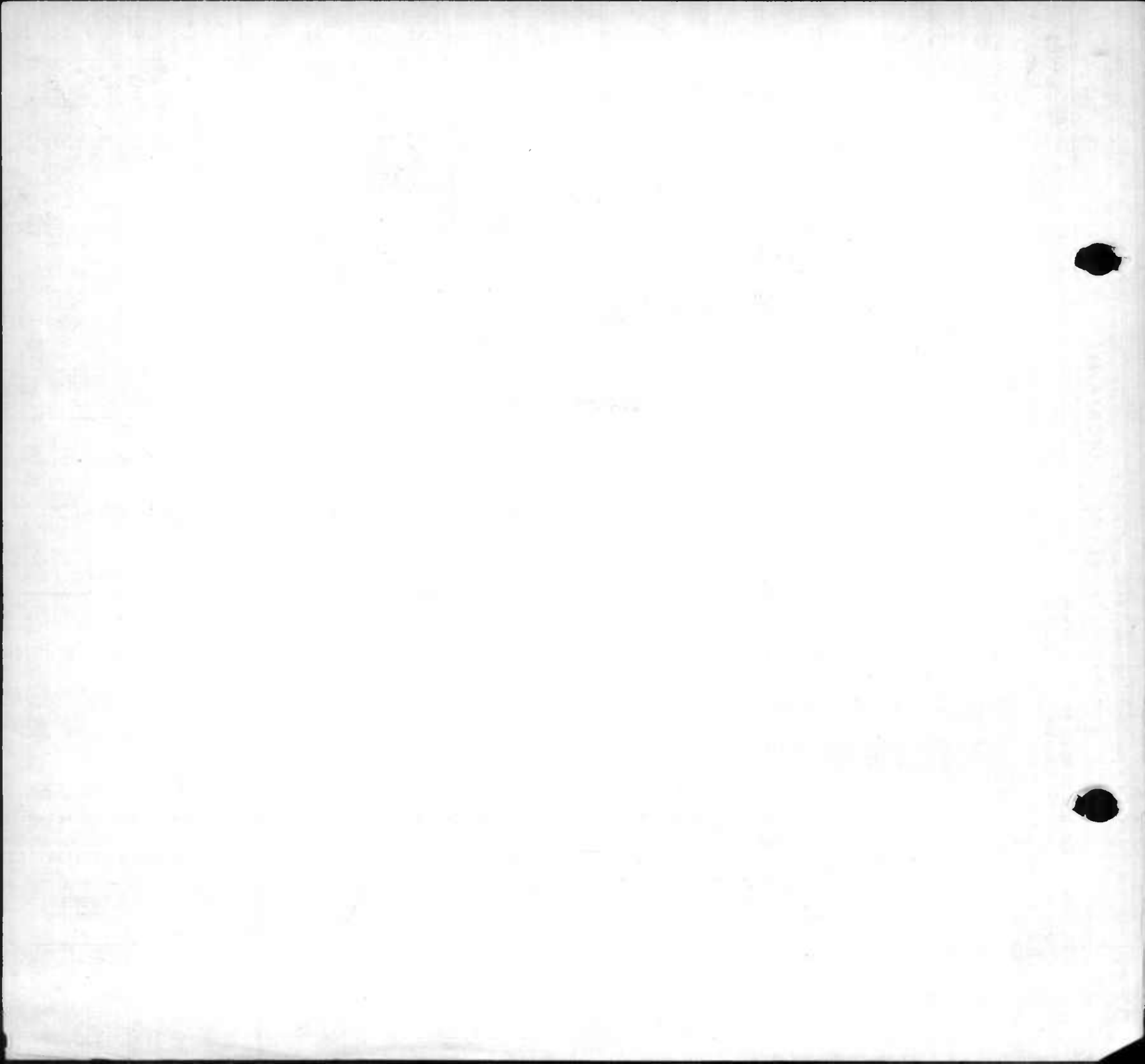
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 4999</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 4999</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Greenawalt, Eugene C.</i>		2. DATE AND HOUR OF DEATH <i>May 10, 1965 2:55 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>15-10</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 15</i>			
				D. STREET ADDRESS (If rural, give location) <i>Haven Nursing Home, 3839 Penhurst Ave.</i>			
5. SEX <i>M.</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>10-23-1882</i>	9. AGE (In years last birthday) <i>82</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home Sales</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>E.M. CROCKER CO.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>T.S. GREENAWALT</i>				14. MOTHER'S MAIDEN NAME <i>ALICE SMITH</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown NO</i>				16. SOCIAL SECURITY NO. <i>215-079591</i>		17. INFORMANT ADDRESS <i>EHRMAN D. GREENAWALT 4218 PENHURST AVE 15</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>C. V. A.</i> DUE TO (B) <i>Generalized Arteriosclerosis</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>5-10-65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-10</i> 19 <i>65</i> to <i>5-10</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5-10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Ey Koh Koh</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>5-10-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Ey Koh Koh</i>				23D. ADDRESS <i>Ind. General Hospital</i> M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-12-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>SPIRITUS EPISCOPAL CHURCH CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>PERRYMAN MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 11 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Sullivan</i>		25C. FUNERAL DIRECTOR <i>HARRISON JENKINS &amp; SONS</i>		ADDRESS <i>4905 YORK RD. BALTO. 12</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 65 5000					CERTIFICATE OF DEATH					Registered No. 65 5000					
M.E. CASE NO.					1. NAME OF DECEASED (Type or Print) Gertrude M. Kennedy					2. DATE AND HOUR OF DEATH May 10, 1965 3:30 P.M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY					5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4809 Crowson Ave.					D. STREET ADDRESS (If rural, give location) 4809 Crowson Ave.										
5. SEX F		6. RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married		8. DATE OF BIRTH 2/27/1890		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Sales		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL BUSINESS OR INDUSTRY Self Employed Confectionary					13. FATHER'S NAME James Kennedy					14. MOTHER'S MAIDEN NAME Mary Birt					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 214-01-6883					17. INFORMANT Miss Genevieve M. Kennedy (Same)					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Chronic carcinoma of Stomach</i> (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos. (?)					19. DATE OF OPERATION 0					20. AUTOPSY? (Yes or No) No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from April 7, 1965 to May 10, 1965 that (I) (we) last saw the deceased alive on May 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					23A. SIGNATURE <i>Frederick J. Vollmer</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED May 11, 1965					
23C. PHYSICIAN'S NAME (Type) Frederick J. Vollmer M.D.					23D. ADDRESS 6100 York Road										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 5/13/1965					24C. NAME of CEMETERY or CREMATORY New Cathedral					
24D. LOCATION Baltimore, Md.					25A. DATE REC'D BY HEALTH DEPT. MAY 11 1965					25B. NAME OF REGISTRAR Robert E. Jenkins					
25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.					25D. ADDRESS 4905 York Rd. Balto. 12, Md.										

